Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services
2021 External Quality Review Report
Community Care Behavioral Health

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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 Plans (MCOs).[1] This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2021 EQRs for HealthChoices (HC) Behavioral Health MCOs (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:

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

Scope of EQR Activities

In accordance with the updates to the CMS EQRO Protocols released in late 2020[2], 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. Validation of Network Adequacy
V. Quality Studies
VI. 2020 Opportunities for Improvement – MCO Response
VII. 2021 Strengths and Opportunities for Improvement
VIII. 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 validation of MCO network adequacy in relation to existing Federal and State standards that are covered in the Review of Compliance with Medicaid Managed Care Regulations, **Section III**. **Section V** discusses the Quality Study for the Certified Community Behavioral Health Clinic federal demonstration and the Integrated Community Wellness Centers program. **Section VI**, 2020 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2020 (MY 2019) EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. **Section VII** includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2021), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, **Section VIII** provides a summary of EQR activities for the MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

I: Validation of Performance Improvement Projects

Objectives

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

In accordance with current BBA regulations, IPRO validates at least one 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.

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

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

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

1. Increase access to appropriate screening, referral, and treatment for members with an Opioid 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 performance indicators for the PEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[3] It contains two submeasures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure 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."[4] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe Alcohol Use Disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

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

This PIP project will extend from January 2021 through December 2023, with initial PIP proposals submitted in 2020 and a final report due in September 2024. The report marks the 18th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

Technical Methods of Data Collection and Analysis

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

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

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls will be to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. Plans will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, rather than two semiannual submissions, MCOs will submit only one PIP interim report each September starting in 2021.

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

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

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial, and non-compliance.

Findings

The MCO successfully submitted a PEDTAR PIP proposal in the fall of 2020 based on an initial baseline period of July 1, 2019, through June 30, 2020. Implementation began in early 2021. The MCO subsequently resubmitted a revised proposal based on the full CY 2020 data with goals, objectives, and interventions recalibrated as needed. IPRO reviewed all baseline PIP submissions for adherence to PIP design principles and standards, including alignment with the Statewide PIP aims and objectives as well as internal consistency and completeness. Clinical intervention highlights include application of the Cascade of Care model with emphasis on warm handoffs and continuity of care, telehealth to support MAT, and increasing SUD screening and referrals in the primary care setting. For its population-based prevention strategy component, CCBH is developing educational MAT toolkits and an anti-stigma campaign focused on reducing SUD stigma in the racial and social justice context highlighting cultural awareness.

II: Validation of Performance Measures

Objectives

In MY 2020, OMHSAS's HealthChoices Quality Program required MCOs to run three performance measures as part of their quality assessment and performance improvement (QAPI) program: the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), a PA-specific Follow-Up After Hospitalization for Mental Illness, and a PA-specific Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2020. IPRO validated all three performance measures reported by each MCO for MY 2020 to ensure that the performance measures were implemented to specifications and state reporting requirements (42 C.F.R. § 438.330(b)(2).

Follow-Up After Hospitalization for Mental Illness

This performance measure assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing county, 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 2020 (MY 2019), the National Committee for Quality Assurance (NCQA) added the following reporting strata for FUH, ages: 6–17, 18–64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are broken out by ages: 6–17, 18–64, and 6 and over (All Ages).

Measure Selection and Description

In accordance with DHS guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population were: product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

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

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

Eligible Population for HEDIS Follow-Up

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2020 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, 2020;
- 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, 2020, 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, 2020. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2020 methodology for the Follow-Up After Hospitalization for Mental Illness measure.

HEDIS Follow-Up Indicators

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

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

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

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

Eligible Population for PA-Specific Follow-Up

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2020 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a principal diagnosis of mental illness occurring between January 1 and December 2, 2020;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 2, 2020, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 2, 2020. The PA-specific measure has been adjusted to allow discharges up through December 2, 2020, which allows for the full 30-day follow-up period where same-day follow-up visits may be counted in the numerator.

PA-Specific Follow-Up Indicators

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

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

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

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

Quality Indicator Significance

Mental health disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2019, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year while an estimated 11.4 million adults in the nation had serious mental illness in the past year, which corresponds to 4.6% of all U.S. adults.[6] 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.[7] Roughly one-third of adults with serious persistent mental illness (SPMI) in any given year did not receive any mental health services, showing a disparity among those with SPMI.[8] Further research suggests that more than half of those with SPMI did not receive services because they could not afford the cost of care.[9] Cost of care broke down as follows: 60.8% of 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.[10] For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcomes and to prevent long-term deterioration in people with severe and persistent mental illness.[11] As noted in *The State of Health Care Quality Report,*[12] appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses and the likelihood of recurrence. An outpatient visit within at least 30 days (ideally, 7 days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments.[13] With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services.[14] One way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact.[15]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of behavioral health care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[16] Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow up with outpatient care.[17]

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[18] 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. MY 2020 results will be examined in the context of the COVID-19 pandemic, which has been implicated in rising prevalence of mental illness.[20] While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge 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 2020 study conducted in 2021 was the 12th 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 2020. 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 2020 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 2, 2020;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event; and
- The claim was clearly identified as a discharge.

The numerator comprised members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge. One significant change to this specification is the extension of the end date for discharges from December 1st to December 2nd to accommodate the full 30 days before the end of the measurement year.

Technical Methods of Data Collection and Analysis

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs for each Primary Contractor participating in the current study. The source for all administrative data was the BH-MCOs' transactional claims systems. Each BH-MCO was also required to submit the follow-up rates calculated for the four indicators, along with their data files for validation purposes. The BH-MCOs were given the opportunity for resubmission, as necessary.

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2020 (MY 2019), 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 2020 also coincided with a more prospective and proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2020 for both the 7-day and 30-day FUH All Ages rates based on their MY 2019 results. These MY 2019 results were reported in the 2020 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 VI**.

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

Although not part of this report, OMHSAS sponsored in 2020 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 2020). 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 2019 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 2020) numerator,
*N*2 = Prior year (MY 2019) numerator,
*D*1 = Current year (MY 2020) denominator, and
*D*2 = Prior year (MY 2019) 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 2020) quality indicator rate, and
*p*2 = Prior year (MY 2019) 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.

Conclusions and Comparative Findings

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 and 18-64 years old age group are compared to the HEDIS 2020 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 are not compared to HEDIS benchmarks.

I: HEDIS Follow-Up Indicators

(a) Age Group: 18–64 Years Old

Table 2.1 shows the MY 2020 results for both the HEDIS 7-day and 30-day follow-up measures for members 18 to 64 years old compared to MY 2019.

Table 2.1: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
QI1 - HEDIS FUH 7-Day Follow-up (18-64 Years)									
Statewide	10454	28699	**36.4%**	35.9%	37.0%	35.9%	0.5	NO	Below 75th Percentile, Above 50th Percentile
CCBH	4968	11628	**42.7%**	41.8%	43.6%	41.9%	0.8	NO	Below 75th Percentile, Above 50th Percentile
Allegheny	1037	2456	**42.2%**	40.2%	44.2%	40.0%	2.2	NO	Below 75th Percentile, Above 50th Percentile
Blair	201	505	**39.8%**	35.4%	44.2%	37.8%	2.0	NO	Below 75th Percentile, Above 50th Percentile

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
Berks	374	887	**42.2%**	38.9%	45.5%	35.8%	6.4	YES	Below 75th Percentile, Above 50th Percentile
Bedford-Somerset	89	207	**43.0%**	36.0%	50.0%	33.0%	10.0	NO	Below 75th Percentile, Above 50th Percentile
Chester	287	623	**46.1%**	42.1%	50.1%	41.3%	4.7	NO	At or Above 75th Percentile
CMP	209	532	**39.3%**	35.0%	43.5%	49.0%	-9.8	YES	Below 75th Percentile, Above 50th Percentile
Erie	337	820	**41.1%**	37.7%	44.5%	41.3%	-0.2	NO	Below 75th Percentile, Above 50th Percentile
Lycoming-Clinton	139	372	**37.4%**	32.3%	42.4%	37.8%	-0.5	NO	Below 75th Percentile, Above 50th Percentile
NBHCC	735	1519	**48.4%**	45.8%	50.9%	49.5%	-1.2	NO	At or Above 75th Percentile
NCSO	1165	2767	**42.1%**	40.2%	44.0%	43.9%	-1.8	NO	Below 75th Percentile, Above 50th Percentile
York-Adams	395	940	**42.0%**	38.8%	45.2%	36.6%	5.4	YES	Below 75th Percentile, Above 50th Percentile
QI2 - HEDIS FUH 30-Day Follow-up (18-64 Years)									
Statewide	15978	28699	**55.7%**	55.1%	56.3%	55.8%	-0.1	NO	Below 75th Percentile, Above 50th Percentile
CCBH	7245	11628	**62.3%**	61.4%	63.2%	62.3%	0.0	NO	Below 75th Percentile, Above 50th Percentile
Allegheny	1498	2456	**61.0%**	59.0%	62.9%	58.9%	2.1	NO	Below 75th Percentile, Above 50th Percentile
Blair	329	505	**65.1%**	60.9%	69.4%	68.3%	-3.2	NO	At or Above 75th Percentile
Berks	531	887	**59.9%**	56.6%	63.1%	53.2%	6.6	YES	Below 75th Percentile, Above 50th Percentile
Bedford-Somerset	139	207	**67.1%**	60.5%	73.8%	56.0%	11.1	NO	At or Above 75th Percentile
Chester	368	623	**59.1%**	55.1%	63.0%	56.9%	2.2	NO	Below 75th Percentile, Above 50th Percentile
CMP	332	532	**62.4%**	58.2%	66.6%	67.5%	-5.1	NO	Below 75th Percentile, Above

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
									50th Percentile
Erie	443	820	**54.0%**	50.6%	57.5%	58.3%	-4.2	NO	Below 50th Percentile, Above 25th Percentile
Lycoming-Clinton	216	372	**58.1%**	52.9%	63.2%	58.5%	-0.4	NO	Below 75th Percentile, Above 50th Percentile
NBHCC	1023	1519	**67.3%**	65.0%	69.7%	69.2%	-1.9	NO	At or Above 75th Percentile
NCSO	1762	2767	**63.7%**	61.9%	65.5%	66.7%	-3.0	YES	At or Above 75th Percentile
York-Adams	604	940	**64.3%**	61.1%	67.4%	60.8%	3.5	NO	At or Above 75th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.
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 2020 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.

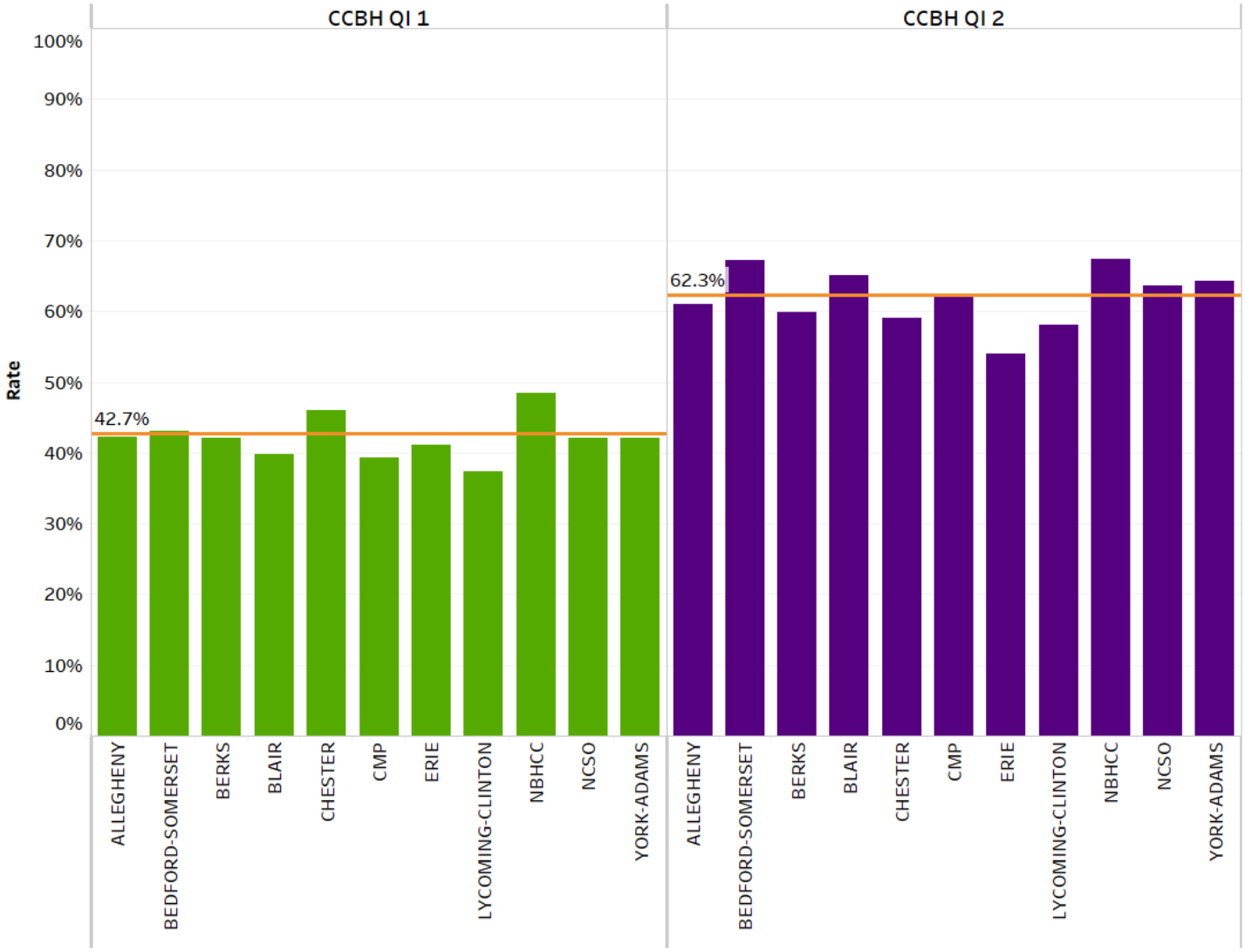
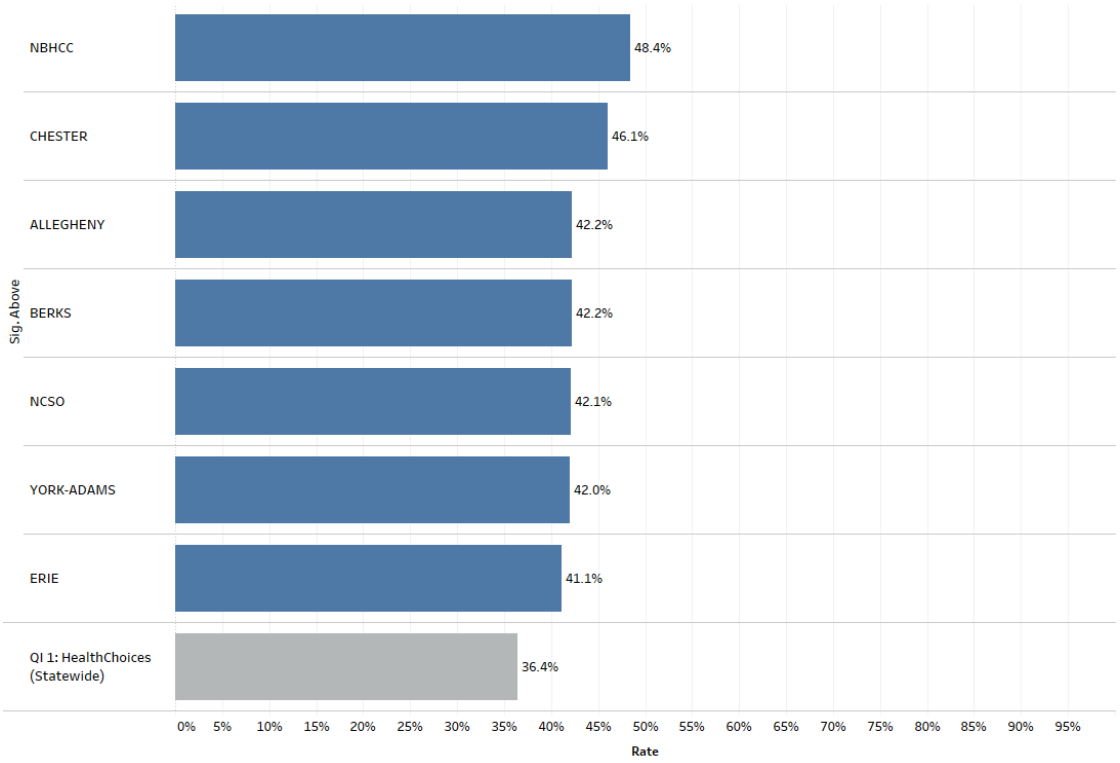


Figure 2.1: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

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.



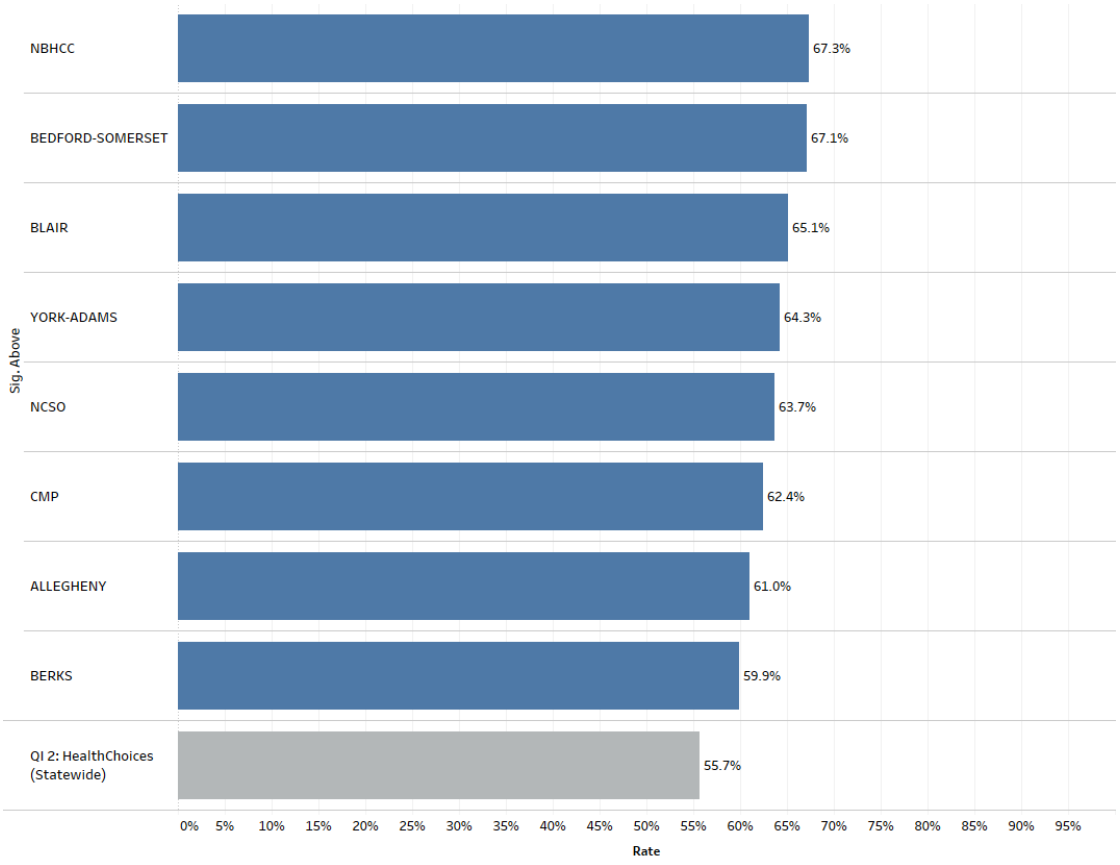


Figure 2.2: Statistically Significant Differences in CCBH Contractor MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years). CCBH contractor MY 2020 HEDIS FUH rates for 18–64 years of age that are significantly different than HC BH (statewide) MY 2020 HEDIS FUH rates (18–64 years).

(b) Overall Population: 6+ Years Old

The MY 2020 HC Aggregate HEDIS and CCBH are shown in **Table 2.2.**

Table 2.2: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
QI1 - HEDIS FUH 7-Day Follow-up (Overall)									
Statewide	14501	36459	**39.8%**	39.3%	40.3%	39.8%	-0.0	NO	Below 75th Percentile, Above 50th Percentile
CCBH	6815	14838	**45.9%**	45.1%	46.7%	45.1%	0.8	NO	Below 75th Percentile, Above 50th Percentile
Allegheny	1424	3120	**45.6%**	43.9%	47.4%	42.9%	2.8	YES	Below 75th Percentile, Above 50th Percentile
Blair	264	621	**42.5%**	38.5%	46.5%	41.7%	0.8	NO	Below 75th Percentile, Above 50th Percentile
Berks	474	1073	**44.2%**	41.2%	47.2%	40.2%	4.0	NO	Below 75th Percentile, Above 50th Percentile
Bedford-Somerset	134	270	**49.6%**	43.5%	55.8%	37.7%	11.9	YES	At or Above 75th Percentile
Chester	374	785	**47.6%**	44.1%	51.2%	45.2%	2.5	NO	At or Above 75th Percentile
CMP	304	706	**43.1%**	39.3%	46.8%	51.3%	-8.2	YES	Below 75th Percentile, Above 50th Percentile
Erie	472	1037	**45.5%**	42.4%	48.6%	45.1%	0.4	NO	Below 75th Percentile, Above 50th Percentile
Lycoming-Clinton	182	473	**38.5%**	34.0%	43.0%	40.8%	-2.3	NO	Below 50th Percentile, Above 25th Percentile
NBHCC	961	1855	**51.8%**	49.5%	54.1%	52.2%	-0.4	NO	At or Above 75th Percentile
NCSO	1670	3654	**45.7%**	44.1%	47.3%	46.6%	-0.8	NO	Below 75th Percentile, Above 50th Percentile
York-Adams	556	1244	**44.7%**	41.9%	47.5%	41.7%	2.9	NO	Below 75th Percentile, Above 50th Percentile
QI2 - HEDIS FUH 30-Day Follow-up (Overall)									
Statewide	21673	36459	**59.4%**	58.9%	60.0%	60.3%	-0.9	YES	Below 50th Percentile, Above 25th Percentile
CCBH	9745	14838	**65.7%**	64.9%	66.4%	66.1%	-0.4	NO	Below 75th Percentile, Above 50th Percentile

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
Allegheny	2009	3120	**64.4%**	62.7%	66.1%	62.3%	2.1	NO	Below 75th Percentile, Above 50th Percentile
Blair	425	621	**68.4%**	64.7%	72.2%	71.5%	-3.0	NO	At or Above 75th Percentile
Berks	666	1073	**62.1%**	59.1%	65.0%	58.4%	3.6	NO	Below 75th Percentile, Above 50th Percentile
Bedford-Somerset	195	270	**72.2%**	66.7%	77.8%	59.6%	12.6	YES	At or Above 75th Percentile
Chester	478	785	**60.9%**	57.4%	64.4%	60.8%	0.1	NO	Below 75th Percentile, Above 50th Percentile
CMP	462	706	**65.4%**	61.9%	69.0%	71.8%	-6.4	YES	Below 75th Percentile, Above 50th Percentile
Erie	614	1037	**59.2%**	56.2%	62.2%	61.9%	-2.7	NO	Below 50th Percentile, Above 25th Percentile
Lycoming-Clinton	288	473	**60.9%**	56.4%	65.4%	64.3%	-3.4	NO	Below 75th Percentile, Above 50th Percentile
NBHCC	1300	1855	**70.1%**	68.0%	72.2%	72.3%	-2.2	NO	At or Above 75th Percentile
NCSO	2467	3654	**67.5%**	66.0%	69.0%	69.8%	-2.3	YES	Below 75th Percentile, Above 50th Percentile
York-Adams	841	1244	**67.6%**	65.0%	70.2%	66.3%	1.3	NO	At or Above 75th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; 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 2020 HEDIS follow-up rates for CCBH and its associated Primary Contractors. The orange line represents the MCO average.

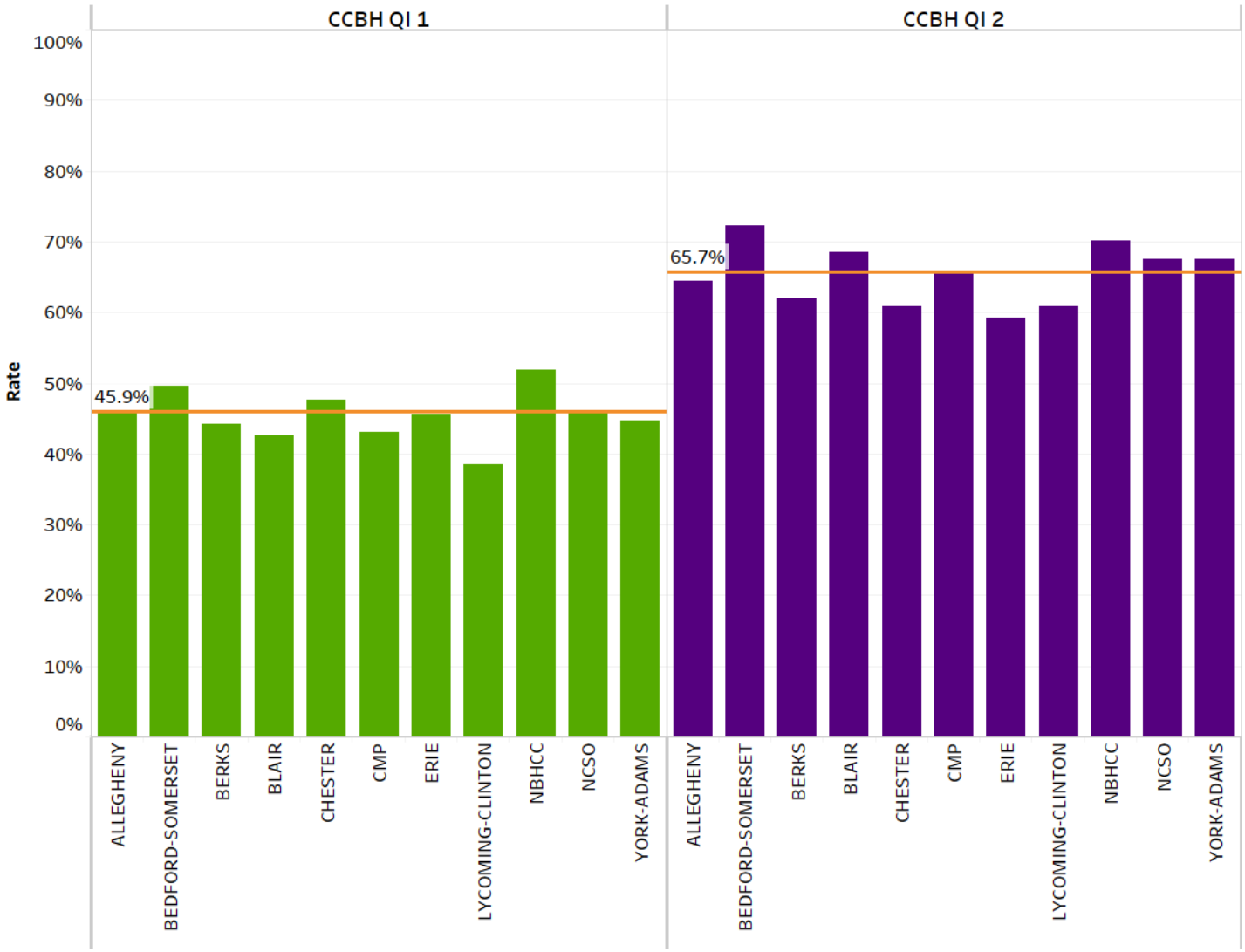


Figure 2.3: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

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.

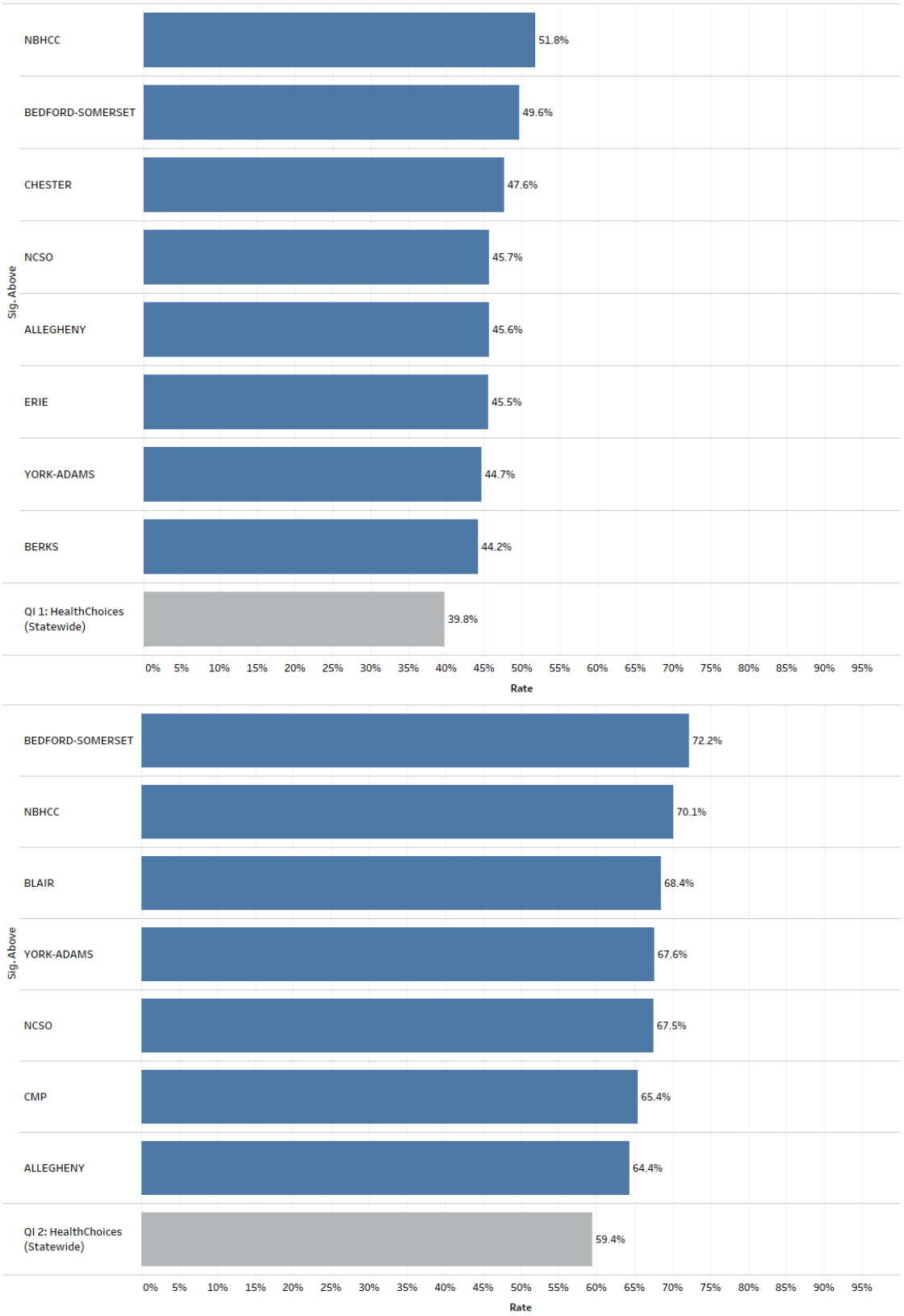


Figure 2.4: Statistically Significant Differences in CCBH Contractor MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages). CCBH contractor MY 2020 HEDIS FUH rates for all ages that are significantly different than HC BH (statewide) MY 2020 HEDIS FUH rates (all ages).

(c) Age Group: 6–17 Years Old

Table 2.3 shows the MY 2020 results for both the HEDIS 7-day and 30-day follow-up measures for members aged 6–17 years compared to MY 2019.

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

	MY 2020						MY 2020 Rate Comparison to MY 2019	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD
QI1 - HEDIS FUH 7-Day Follow-up (6-17 Years)								
Statewide	3860	6993	**55.2%**	54.0%	56.4%	55.4%	-0.2	NO
CCBH	1759	2904	**60.6%**	58.8%	62.4%	57.8%	2.8	YES
Allegheny	354	568	**62.3%**	58.3%	66.4%	57.0%	5.3	NO
Blair	58	104	**55.8%**	45.7%	65.8%	53.7%	2.1	NO
Berks	96	163	**58.9%**	51.0%	66.8%	59.6%	-0.7	NO
Bedford-Somerset	44	60	**73.3%**	N/A	N/A	65.0%	8.3	N/A
Chester	86	152	**56.6%**	48.4%	64.8%	61.1%	-4.6	NO
CMP	94	158	**59.5%**	51.5%	67.5%	57.9%	1.5	NO
Erie	128	191	**67.0%**	60.1%	73.9%	63.4%	3.6	NO
Lycoming-Clinton	42	99	**42.4%**	N/A	N/A	47.1%	-4.7	N/A
NBHCC	218	314	**69.4%**	64.2%	74.7%	64.1%	5.3	NO
NCSO	482	807	**59.7%**	56.3%	63.2%	55.5%	4.2	NO
York-Adams	157	288	**54.5%**	48.6%	60.4%	57.0%	-2.5	NO
QI2 - HEDIS FUH 30-Day Follow-up (6-17 Years)								
Statewide	5393	6993	**77.1%**	76.1%	78.1%	78.8%	-1.7	YES
CCBH	2358	2904	**81.2%**	79.8%	82.6%	81.1%	0.1	NO
Allegheny	467	568	**82.2%**	79.0%	85.5%	79.8%	2.4	NO
Blair	88	104	**84.6%**	77.2%	92.0%	83.2%	1.4	NO
Berks	127	163	**77.9%**	71.2%	84.6%	80.7%	-2.8	NO
Bedford-Somerset	54	60	**90.0%**	N/A	N/A	85.0%	5.0	N/A
Chester	106	152	**69.7%**	62.1%	77.4%	77.2%	-7.5	NO
CMP	126	158	**79.7%**	73.2%	86.3%	84.6%	-4.9	NO
Erie	160	191	**83.8%**	78.3%	89.3%	80.6%	3.2	NO
Lycoming-Clinton	71	99	**71.7%**	N/A	N/A	77.5%	-5.8	N/A
NBHCC	268	314	**85.4%**	81.3%	89.4%	84.3%	1.0	NO
NCSO	661	807	**81.9%**	79.2%	84.6%	80.3%	1.6	NO
York-Adams	230	288	**79.9%**	75.1%	84.7%	83.0%	-3.1	NO

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; 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 2020 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.

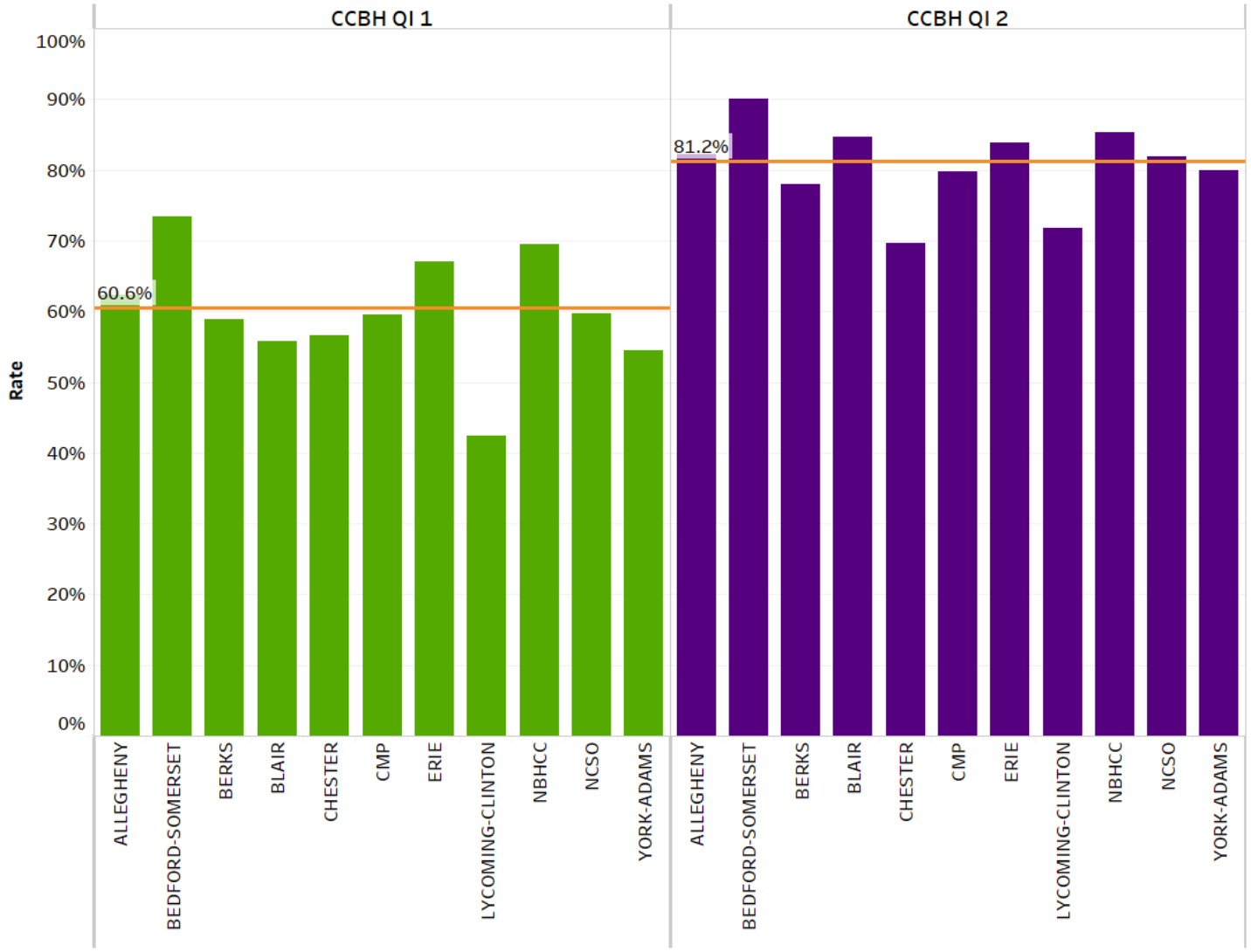


Figure 2.5: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

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.

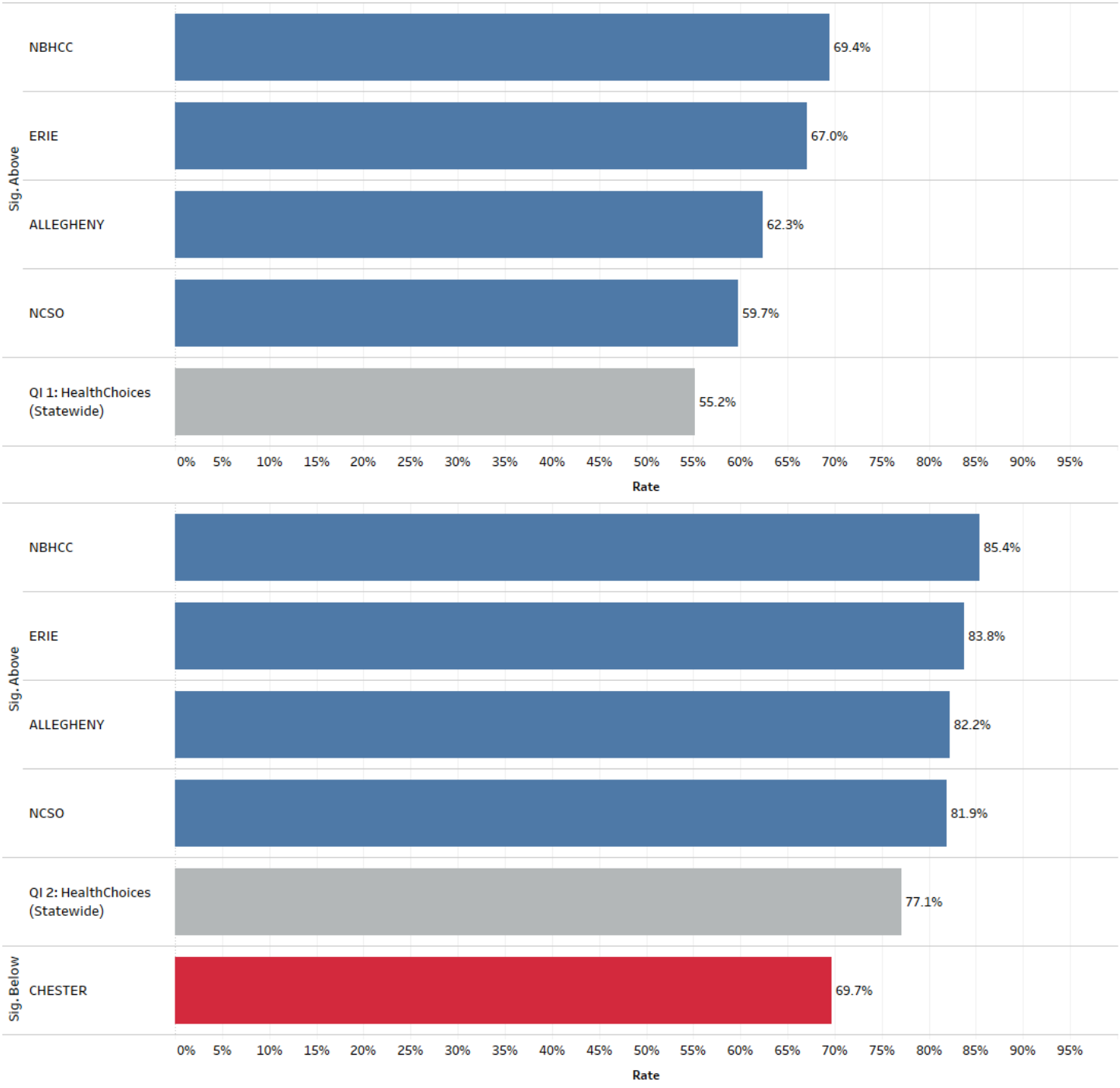


Figure 2.6: Statistically Significant Differences in CCBH Contractor MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years). CCBH contractor MY 2020 HEDIS FUH rates for 6–17 years of age that are significantly different than HC BH (statewide) MY 2020 HEDIS FUH rates (6–17 years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

Table 2.4 shows the MY 2020 PA-specific FUH 7- and 30-day follow-up indicators for all ages compared to MY 2019.

Table 2.4: MY 2020 PA-Specific FUH 7- and 30-Day Follow-Up Indicators (All Ages)

	MY 2020						MY 2020 Rate Comparison to MY 2019	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD
QI A - PA-Specific FUH 7-Day Follow-up (Overall)								
Statewide	19124	36580	**52.3%**	51.8%	52.8%	52.9%	-0.6	NO
CCBH	8585	14883	**57.7%**	56.9%	58.5%	57.3%	0.4	NO
Allegheny	1885	3129	**60.2%**	58.5%	62.0%	55.9%	4.3	YES
Blair	380	622	**61.1%**	57.2%	65.0%	56.9%	4.2	NO
Berks	609	1073	**56.8%**	53.7%	59.8%	52.7%	4.1	YES
Bedford-Somerset	167	270	**61.9%**	55.9%	67.8%	50.0%	11.9	YES
Chester	425	789	**53.9%**	50.3%	57.4%	52.8%	1.1	NO
CMP	379	708	**53.5%**	49.8%	57.3%	57.9%	-4.4	NO
Erie	620	1038	**59.7%**	56.7%	62.8%	62.2%	-2.4	NO
Lycoming-Clinton	256	475	**53.9%**	49.3%	58.5%	60.5%	-6.6	YES
NBHCC	1131	1864	**60.7%**	58.4%	62.9%	58.5%	2.1	NO
NCSO	2059	3667	**56.1%**	54.5%	57.8%	57.4%	-1.3	NO
York-Adams	674	1248	**54.0%**	51.2%	56.8%	61.2%	-7.2	YES
QI B - PA-Specific FUH 30-Day Follow-up (Overall)								
Statewide	24982	36580	**68.3%**	67.8%	68.8%	69.5%	-1.2	YES
CCBH	10881	14883	**73.1%**	72.4%	73.8%	73.7%	-0.6	NO
Allegheny	2326	3129	**74.3%**	72.8%	75.9%	71.4%	2.9	YES
Blair	482	622	**77.5%**	74.1%	80.9%	78.1%	-0.6	NO
Berks	764	1073	**71.2%**	68.4%	74.0%	69.7%	1.5	NO
Bedford-Somerset	213	270	**78.9%**	73.8%	83.9%	67.5%	11.3	YES
Chester	525	789	**66.5%**	63.2%	69.9%	66.7%	-0.2	NO
CMP	509	708	**71.9%**	68.5%	75.3%	76.3%	-4.4	NO
Erie	728	1038	**70.1%**	67.3%	73.0%	72.2%	-2.1	NO
Lycoming-Clinton	336	475	**70.7%**	66.5%	74.9%	78.0%	-7.3	YES
NBHCC	1405	1864	**75.4%**	73.4%	77.4%	75.1%	0.2	NO
NCSO	2681	3667	**73.1%**	71.7%	74.6%	75.7%	-2.6	YES
York-Adams	912	1248	**73.1%**	70.6%	75.6%	76.9%	-3.9	YES

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.

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 2020 PA-specific follow-up rates for CCBH and its associated Primary Contractors. The orange line represents the MCO average.

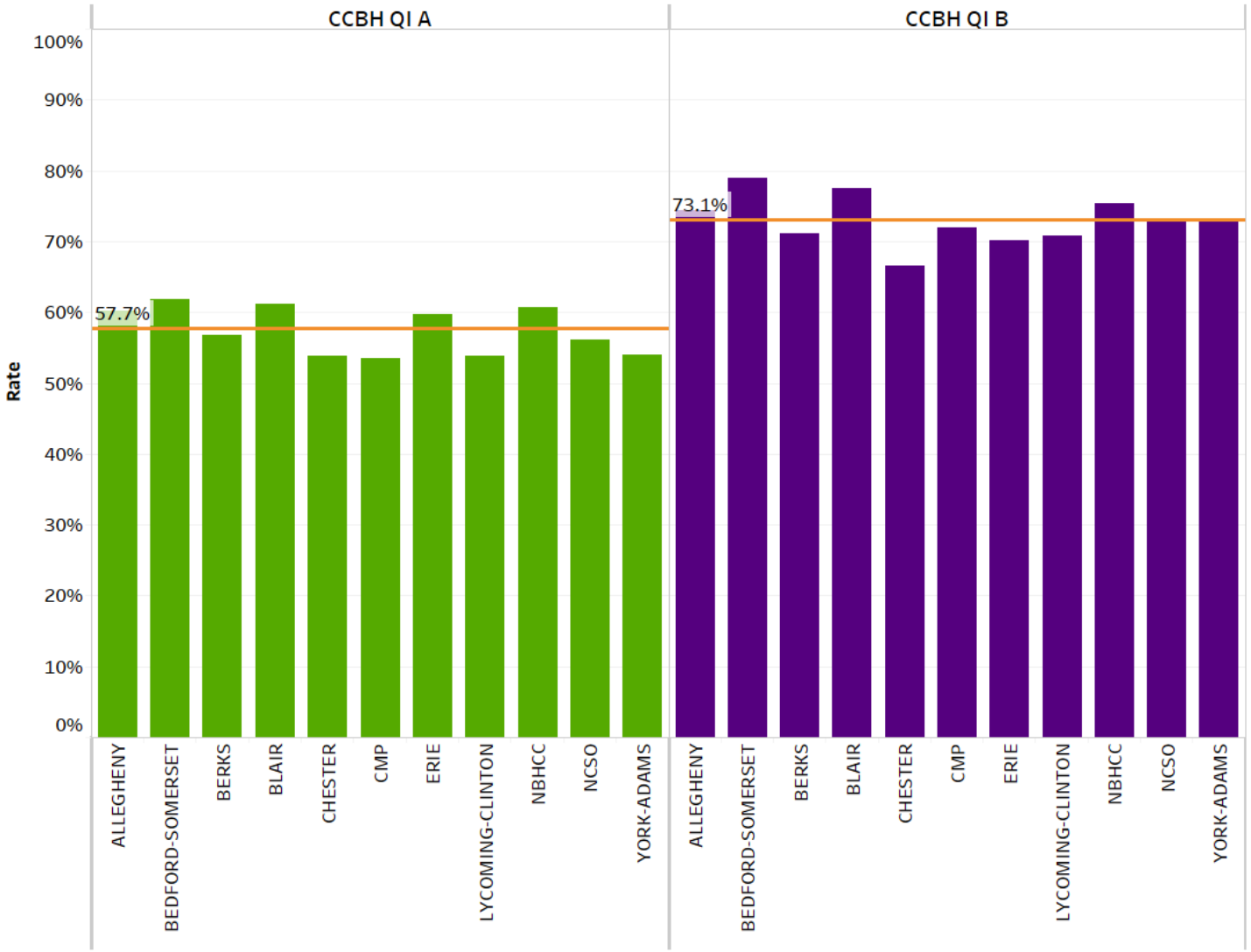


Figure 2.7: MY 2020 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

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

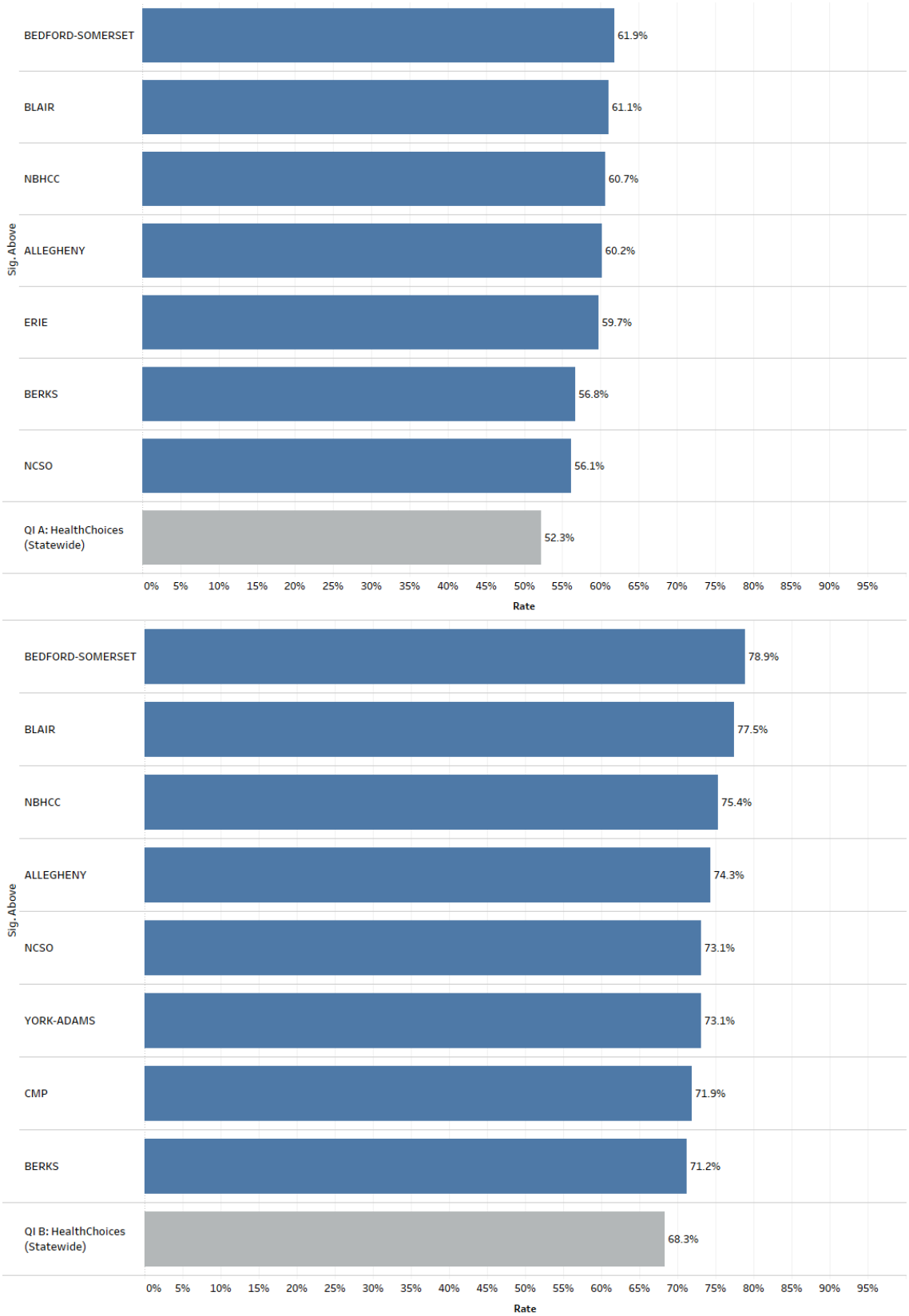


Figure 2.8: Statistically Significant Differences in CCBH Contractor MY 2020 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages). CCBH contractor MY 2020 PA-Specific FUH rates for all ages that are significantly different than HC BH (statewide) MY 2020 PA-specific FUH rates (all ages).

III. Readmission Indicators

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2020 to MY 2019 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 2020 REA Readmission Indicators

	MY 2020						MY 2020 Rate Comparison to MY 2019	
				95% CI				
Measure[1]	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[2]	SSD
Inpatient Readmission								
Statewide	6134	45174	**13.6%**	13.3%	13.9%	13.5%	0.1	NO
CCBH	2282	18397	**12.4%**	11.9%	12.9%	13.3%	-0.9	YES
Allegheny	459	3856	**11.9%**	10.9%	12.9%	13.1%	-1.2	NO
Blair	122	794	**15.4%**	12.8%	17.9%	16.0%	-0.6	NO
Berks	178	1376	**12.9%**	11.1%	14.7%	16.9%	-3.9	YES
Bedford-Somerset	30	313	**9.6%**	6.2%	13.0%	16.6%	-7.0	YES
Chester	126	917	**13.7%**	11.5%	16.0%	14.5%	-0.7	NO
CMP	125	881	**14.2%**	11.8%	16.5%	15.1%	-0.9	NO
Erie	181	1336	**13.5%**	11.7%	15.4%	14.6%	-1.0	NO
Lycoming-Clinton	58	568	**10.2%**	7.6%	12.8%	13.6%	-3.4	NO
NBHCC	288	2392	**12.0%**	10.7%	13.4%	12.2%	-0.1	NO
NCSO	501	4374	**11.5%**	10.5%	12.4%	12.5%	-1.0	NO
York-Adams	214	1590	**13.5%**	11.8%	15.2%	10.2%	3.2	YES

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

[2] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.

MY: measurement year; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; 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 2020 readmission rates for CCBH Primary Contractors compared to the orange line representing the MCO average.

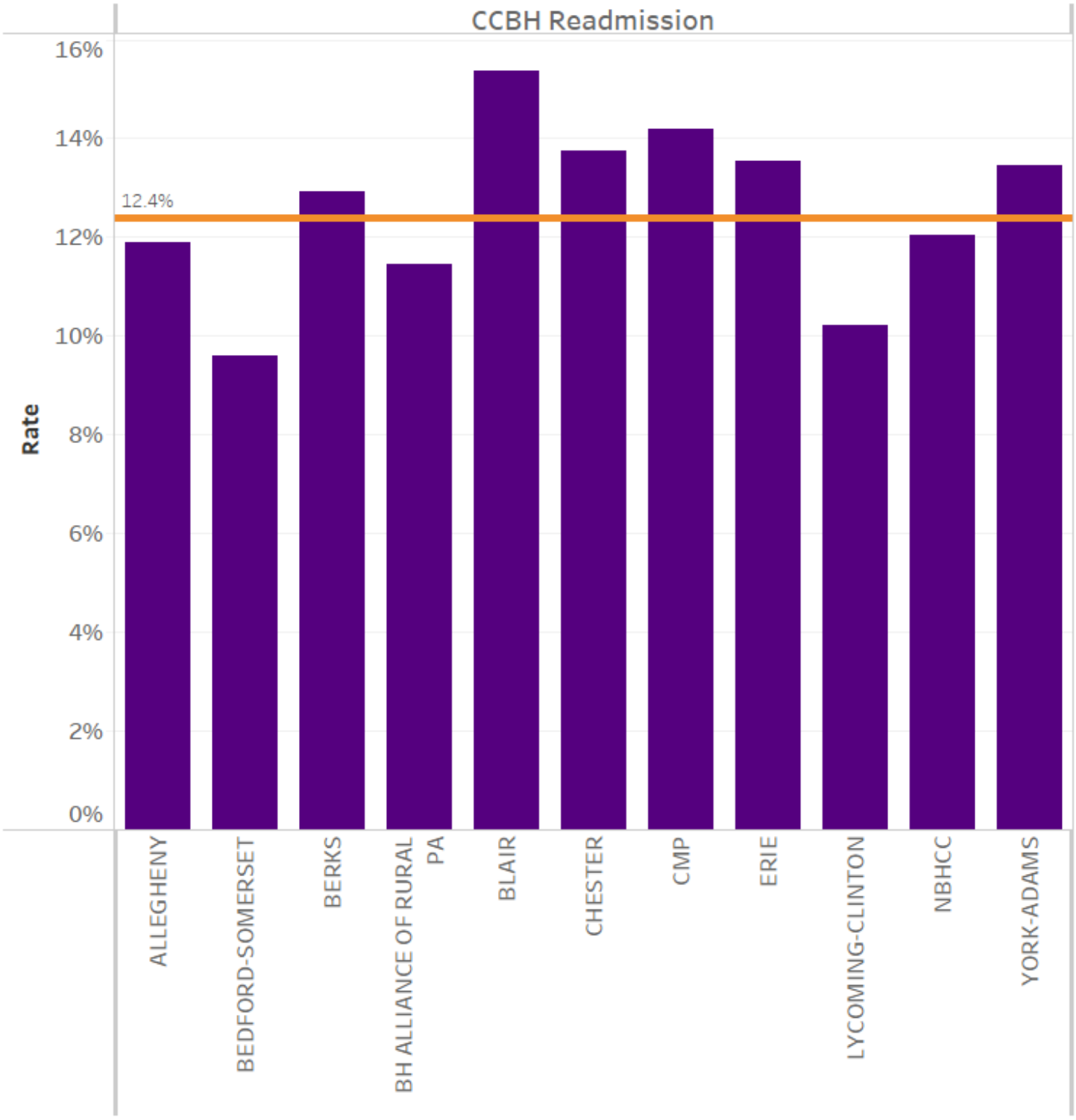


Figure 2.9: MY 2020 REA Readmission Rates for CCBH Primary Contractors.

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.

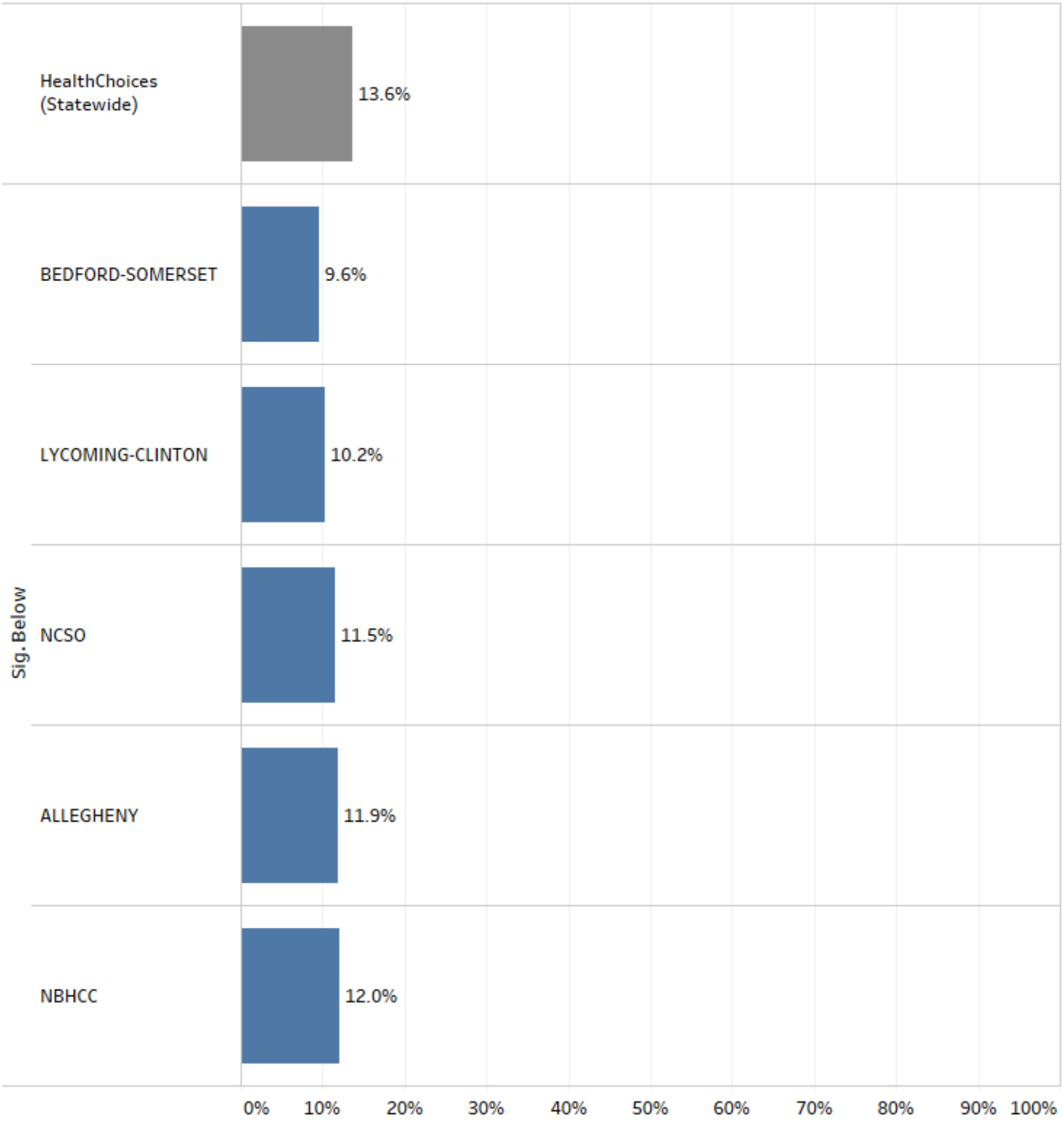


Figure 2.10: Statistically Significant Differences in CCBH Contractor MY 2020 REA Readmission Rates (All Ages). CCBH contractor MY 2020 REA readmission rates for all ages that are significantly different than HC BH (statewide) MY 2020 REA readmission rates (all ages).

Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS MY 2020 specifications, including removal of the mental health provider requirement for specific types of follow-up visits, and the addition to the numerator of certain place of service types, including visits in behavioral healthcare settings and telehealth. MY 2020 also coincided with the COVID-19 pandemic, which likely negatively impacted the ability of payers and providers to ensure timely follow-up services after hospitalization. Understanding the precise nature and extent of that impact, however, will require more research. 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. The following are recommendations that are informed by the MY 2020 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 2020. 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. 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 2021 (MY 2020) 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 2021 (MY 2020) 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 2021 (MY 2020) FUH Rates Report in conjunction with the corresponding 2021 (MY 2020) 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.
- Several contractors turned in follow-up rates that met or exceeded the HEDIS 2021 75th percentile. Other BH-MCOs could benefit from drawing lessons or at least general insights from their successes.

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 2020 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%. The only Primary Contractor that fell below 10% and met the statewide goal was Bedford-Somerset. 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 2020 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 2020 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 2019, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A new PIP starting in 2020 builds on the previous PIP by, among other things, including a performance indicator that measures MH-related readmissions within 30 days of a discharge for SUD. BH-MCOs are expected to bring about meaningful improvement in BH readmission rates for this subpopulation with comorbid BH conditions and for their HC BH members more generally. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.
- The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate 2021 (MY 2020) 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 2021 (MY 2020) REA Rates Report in conjunction with the aforementioned 2021 (MY 2020) 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

Objectives

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) 2020, 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: CCBH HealthChoices Oversight Entities, Primary Contractors and Counties

HealthChoices 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
PA Department of Human Services – OMHSAS	Community Care Behavioral Health Organization	Bradford County
		Cameron County
		Centre County

HealthChoices Oversight Entity	Primary Contractor	County
	Otherwise known as North/Central State Option (NCSO) for this review	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

CCBH: Community Care Behavioral Health.

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 2020, 2019, and 2018). 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&Rs are also used.

Description of Data Obtained

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2020 and entered into the PEPS Application as of March 2021 for RY 2020. 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 previously 2nd-level grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[21] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included 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 2020 are presented here under the new rubric of the three "CMS sections": Standards, including Enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up were correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. 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 2020 (RY 2019), two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

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 2020 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 2020, RY 2019, and RY 2018 provided the information necessary for the 2020 assessment. Those triennial standards not reviewed through the PEPS system in RY 2020 were evaluated on their performance based on RY 2019 and/or RY 2018 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 2020, 2019, 2018). In addition, 18 OMHSAS-specific substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific substandards that are not required as part of BBA regulations but are reviewed within the 3-year cycle to evaluate the BH-MCO and the associated HC Oversight Entity against other state-specific Structure and Operations Standards.

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 2018–2020). Substandard counts under RY 2020 comprised annual and triennial substandards. Substandard

counts under RYs 2019 and 2018 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	2020	2019	2018
CMS EQR Protocol 3 "sections": Standards, including enrollee rights and protections					
Assurances of adequate capacity and services (42 C.F.R. § 438.207)	5	-	5	-	-
Availability of Services (42 C.F.R § 438.206, 42 C.F.R. § 10(h))	24	-	16	-	2
Confidentiality (42 C.F.R. § 438.224)	1	-	1	6	-
Coordination and continuity of care (42 C.F.R. § 438.208)	2	-	-	-	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	-	2	-	2
Health information systems (42 C.F.R. § 438.242)	1	-	1	-	
Practice guidelines (42 C.F.R. § 438.236)	6	-	4	-	2
Provider selection (42 C.F.R. § 438.214)	3	-		3	-
Subcontractual relationships and delegation (42 C.F.R. § 438.230)	8	-	8	-	-
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program (42 C.F.R. § 438.330)	26	-	26	-	-
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems (42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424)	14	-	2	-	12
Total	**94**	-	**65**	**9**	**20**

[1] The total number of substandards required for the evaluation of 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; CMS: Centers for Medicare and Medicaid Services; EQR: external quality review; C.F.R: Code of Federal Regulations.

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.

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[22] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) Program, and Grievance System.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the 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 2020.

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	Compliant	All CCBH Primary Contractors	1.1, 1.2, 1.4, 1.5, 1.6	-	-
Availability of Services 42 C.F.R § 438.206, 42 C.F.R. § 10(h)	24	Compliant	All CCBH Primary Contractors	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 28.2, 93.1, 93.2, 93.3, 93.4	-	-
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	4	Compliant	All CCBH Primary Contractors	28.1, 28.2, 72.1, 72.2	-	-

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
C.F.R. § 441, Subpart B, and § 438.114						
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	Compliant	All CCBH Primary Contractors	28.1, 28.2, 93.1, 93.2, 93.3, 93.4	-	-
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 9 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 54 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.

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	Compliant	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, 93.3, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4	-	-

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

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 26 substandards.

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, 72.1, 72.2	68.3, 68.4, 68.7, 68.9, 71.3, 71.7	-

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

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 8 substandards and partially compliant with 6 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).

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.

IV: Validation of Network Adequacy

Objectives

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

Description of Data Obtained

For the 2020 review year, the BH-MCO's network adequacy was assessed based on compliance with certain federal and OMHSAS-specific standards that were crosswalked to standards falling directly or indirectly under 42 CFR § 438.68(b) (1)(iii) and 457.1218. Compliance status was determined as part of the larger assessment of compliance with MMC regulations. As of MY 2020, EQR validation protocols for assessing network adequacy had not been published by CMS. Since the publication of the *2020 Medicaid and CHIP Managed Care Final Rule*, OMHSAS is actively reviewing its network adequacy monitoring program to ensure all relevant requirements are covered in the annual validation activity going forward. For behavioral health, those requirements include: quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[23]

Findings

Table 4.1 describes the RY 2020 compliance status of CCBH with respect to network adequacy standards that were in effect in 2020. Definitions for most standards may be found in **Section III**, Compliance with Medicaid Managed Care Regulations. The following standards are specific to validation of network adequacy (any substandards for which the MCO is not fully compliant are defined further below):

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

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

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

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

Table 4.1: Compliance with Standards Related to Network Adequacy

Standard Description	Substandard Count	MCO Compliance Status	Primary Contractors	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Standard 1	7	Compliant	All CCBH Primary Contractors	1.1, 1.2, 1.4, 1.5, 1.6, 1.7	-	-
Standard 10	3	Compliant	All CCBH Primary Contractors	10.1, 10.2, 10.3	-	-
Standard 11	3	Compliant	All CCBH Primary Contractors	11.1, 11.2, 11.3	-	-
Standard 23	5	Compliant	All CCBH Primary Contractors	23.1, 23.2, 23.3, 23.4, 23.5	-	-
Standard 24	6	Compliant	All CCBH Primary Contractors	24.1, 24.2, 24.3, 24.4, 24.5, 24.6	-	-
Standard 59	1	Compliant	All CCBH Primary Contractors	59.1	-	-
Standard 78	5	Partial	Allegheny, Blair, Lycoming/Clinton, NBHCC, NCSO	78.1, 78.2, 78.3, 78.4, 78.5	-	-
			Berks	78.1, 78.2, 78.3, 78.5	-	78.4
			Carbon/Monroe/Pike, Chester	78.1, 78.2, 78.3, 78.4,	-	78.5
			Erie	78.2, 78.3, 78.4, 78.5	78.1	-
			York/Adams	78.2, 78.3, 78.4, 78.5	-	78.1
Standard 91	15	Compliant	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	-	-
Standard 93	4	Compliant	All CCBH Primary Contractors	93.1, 93.2, 93.3, 93.4	-	-
Standard 99	8	Compliant	All CCBH Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-
Standard 100	1	Compliant	All CCBH Primary Contractors	100.1	-	-

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

For this review, 58 substandards were crosswalked to Network Adequacy. All 58 substandards were reviewed for CCBH and its Primary Contractors. CCBH and these Primary Contractors were compliant with 55 substandards and non-compliant with three.

CCBH was partially compliant with Standard 78 due to non-compliance with three substandards.

Standard 78 (see description above)

Substandard 1: Review of County/Corporation management minutes demonstrate actions taken. BH-MCO written notification of key staff changes received within seven days-watch for high turnover, vacant positions.

Substandard 4: Other: Significant onsite review findings related to Standard 78.

Substandard 5: Updated County Table of Organization - Evidence of sufficient staff.

The finding specific to Standard 78.4, from RY 2018, stated: "Berks County must implement a formal conflict of interest policy and statement for Board/Committee members and PC staff to ensure any person involved in an oversight or advisory role pertaining to the HC-BH program is free of conflicts of interest." A corrective action plan was implemented to remediate the deficiency. Berks County along with CCBH will next be reviewed on Standard 78 for RY 2021.

V: Quality Studies

Objectives

The purpose of this section is to describe quality studies performed in 2020 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the Review Year.[24]

Integrated Community Wellness Centers

In 2020, PA DHS made the decision to discontinue participation in the CCBHC Demonstration but to continue and build on the CCBHC model in a PA DHS-administered Integrated Community Wellness Centers (ICWC) program under an MMC agreement with CMS. The purpose of the CCBHC Demonstration was to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, 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 ICWC clinics. The other services, including targeted case management, peer support, psychiatric rehabilitation services, and intensive community-based mental health care to members of the armed forces and veterans may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of evidence-based practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Under ICWC, the same nine core services of the CCBHC model are provided under PA's 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 invited to participate in the new program.

Description of Data Obtained

Like CCBHC, ICWC features a process measure Dashboard, hosted by the EQRO. Clinics enter monthly, quarterly, and year-to-date (YTD) data into a REDCap project which feeds, on a weekly basis, a server-based Tableau workbook where clinics are able to monitor progress on the implementation of their ICWC model. Using the Dashboard, clinics in 2020 tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and client satisfaction. The Tableau workbook also featured a comparative display that showed clinic and statewide results on each process measure.

Findings

In 2020, the number of individuals receiving at least one core service dropped slightly to just over 17,700 from just over 19,400 in 2019 (the second year of the CCBHC demonstration). The unweighted average (across all the clinics) number of days until initial evaluation was 8 days. In the area of depression screening and follow-up, more than 94% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 3,700 individuals within the ICWC program received drug and alcohol outpatient or intensive outpatient treatment during the period.

Process measures reflect important progress in increasing both the access and quality of community-based care for individuals with behavioral health conditions, but the ICWC quality measures are designed to more meaningfully measure the impact of these efforts. Under the CMS-approved ICWC preprint, a subset of the CCBHC measures is reported to CMS on an annual calendar year basis, along with HEDIS Follow-Up After High Intensity Care for Substance Use Disorder (FUI). **Table 5.1** summarizes how well the ICWC clinics did on quality measures compared to applicable performance targets and national benchmarks.

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

Measure	ICWC Weighted Average	Comparison		
		ICWC 2020 Performance Target	National Benchmark	Benchmark Description
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 7 day	9.9%	N/A (baseline year)	32.45%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 30 day	20.1%	N/A (baseline year)	53.75%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Initiation	74.6%	80.2%	43.0%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Continuation	81.5%	89.6%	54.7%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 7 day	21.5%	26.7%	12.7%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 day	33.7%	38.8%	19.3%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 day	100%	53.4%	39.1%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 day	100%	64.2%	55.2%	HEDIS 2021 Quality Compass 50th percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Initiation	19.0%	28.2%	43.5%	HEDIS 2021 Quality Compass 50th percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Engagement	4.0%	18.8%	14.2%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 7 day	12.0%	30.2%	31.4%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	20.0%	41.6%	52.9%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 7 day	18.1%	43.8%	45.5%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 30 day	26.3%	55.6%	70.0%	HEDIS 2021 Quality Compass 50th percentile
Antidepressant Medication Management (AMM) - Acute	58.0%	48.8%	53.6%	HEDIS 2021 Quality Compass 50th percentile
Antidepressant Medication Management (AMM) - Continuation	81.5%	89.5%	45.7%	HEDIS 2021 Quality Compass 50th percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	56.1%	57.3%	62.1%	HEDIS 2021 Quality Compass 50th percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	72.2%	85.0%	82.1%	HEDIS 2021 Quality Compass 50th percentile

Measure	ICWC Weighted Average	Comparison		
		ICWC 2020 Performance Target	National Benchmark	Benchmark Description
Plan All-Cause Readmissions Rate (PCR)	25%	6.9%	9.9%	HEDIS 2021 Quality Compass 50th percentile
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	52.2%	16.2%	17.1%	MIPS 2021 (eCQM)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	39.7%	26.3%	12.2%	MIPS 2021 (eCQM)
Screening for Depression and Follow-Up Plan (CDF-BH)	36.0%	37.7%	50.2%	MIPS 2021 (CQM)
Depression Remission at Twelve Months (DEP-REM-12)	9.4%	N/A	4.9%	MIPS 2021 (eCQM)
Body Mass Index (BMI) Screening and Follow-Up Plan	35.7%	51.0%	49.2%	MIPS 2021 (eCQM)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)	51.0%	64.5%	68.4%	HEDIS 2021 Quality Compass 50th percentile
Tobacco Use: Screening and Cessation Intervention (TSC)	70.5%	56.0%	60.4%	MIPS 2021 (CQM)
Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	69.2%	51.1%	68.4%	MIPS 2021 (CQM)

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

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

VI: 2020 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 2020 EQR Technical Report and in the 2021 (MY 2020) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in June 2021. The 2021 EQR Technical Report is the 14th 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, 2021, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the MCO responses submitted to IPRO in October 2021 to address partial and non-compliant PEPS standards findings, as well as any additional relevant documentation provided by the BH-MCO.

The request for MCO response to the opportunities for improvement related to MY 2020 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2020 results, in January 2022. 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, 2022.

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 2019, CCBH began to address opportunities for improvement related to compliance categories within the three CMS sections pertaining to compliance with Medicaid Managed Care regulations. Within Compliance with Standards, including Enrollee Rights and Protections, CCBH was partially compliant with the following BBA categories: Assurances of adequate capacity and services, Availability of Services, Coverage and authorization of services, and Practice Guidelines. Within Quality assessment and performance improvement program, CCBH was partially compliant within the same-named category. Within Compliance with Grievance System, CCBH was partially compliant with Grievance and appeal systems. 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 6.1 presents CCBH's responses to opportunities for improvement cited by IPRO in the 2021 (MY 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 6.1: 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 (RY) 2017, RY 2018, and RY 2019 found CCBH to be partially compliant with all three sections in CMS Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/21/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
CCBH 2020.01	Within CMS EQR Protocol 3: Enrollee Rights and Protections Regulations, CCBH was partially compliant on four out of nine categories. The partially compliant categories are: 1. Assurances of adequate capacity and services 2. Availability of Services 3. Coverage and authorization of services 4. Practice guidelines	Date(s) of follow-up action taken through 6/30/21/Ongoing/None	1) Assurances of adequate capacity and services - Program Evaluation Performance Standard (PEPS) Standard 1.1 and 1.2 (RY 2019, partially compliant) Standard 1.1 (RY 2019) and Standard 1.2 (RY 2019) Community Care's 2019 PEPs review indicated Standard 1.1 was met for all our contracts. Standard 1.2 was partially met for Carbon, Monroe, Pike (CMP), the Northeast/NBHCC (NE/NBHCC) and the Berks contract. Each year, Community Care requests waivers for levels of care that do not meet the standard. Standard 1.3 indicates all waivers were submitted and accepted for all contracts.
		Date(s) of follow-up action taken through 6/30/21/Ongoing/None	2) Availability of Services (Access to Care) –PEPS Standards 1.1 and 1.2 (RY2019, partially compliant) Standard 1.1 (RY2019) – see section above Standard 1.2 (RY2019) – see section above
		Date(s) of follow-up action taken through 6/30/21/Ongoing/None	3) Coverage and authorization of services –PEPS Standard 72.1 (RY 2019, partially compliant) Standard 72.1 (RY2019)
		Date(s) of follow-up action taken through 6/30/21/Ongoing/None	4) Practice Guidelines – PEPS Standard 93.3 (RY2017, partially compliant) Standard 93.3 (RY2017)
CCBH 2020.02	Within CMS EQR Protocol 3: Quality Assessment and Performance Improvement Regulations, CCBH was partially compliant with quality assessment and performance improvement program.	Date(s) of follow-up action taken through 6/30/21/Ongoing/None	Quality Assessment and Performance Improvement Regulations - PEPS Standard 93.3 (RY2017, partially compliant) Standard 93.3 (RY2017) – see section above

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 2019 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 2020, CCBH scored below the 75th percentile on both the 7- and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. **Table 6.2** presents CCBH's submission of its RCA and QIP for the FUH All-Ages 7-day measure, and **Table 6.3** 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 6.2: CCBH RCA and QIP for the FUH 7–Day Measure (All Ages)

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)

Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):

The overall opportunity for improvement, which is the focus of this root-cause-analysis and quality improvement plan, was identified using the MY 2020 FUH Goal Report.
Attachments:
MY 2020 FUH Goal Report_01172022_updated

IPRO's Quality Management Dashboard was used to determine disparities in HEDIS 7-day follow-up post hospitalization (FUH). Data was broken into Expansion/Legacy for cohorts with a statistically significant difference.
Attachments:
MY 2020 FUH IPRO Dashboard Disparities

The following information/analysis was used to identify the factors that contributed to underperformance:

- 2021 HealthChoices Membership Analysis
- 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 7-day follow-up appointments in aggregate and contract specific groupings.
- Barrier analysis of the North Central State Option completed by the Behavioral Health Alliance of Rural Pennsylvania.
- Board Quality Improvement Committee

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:

The following opportunity for improvement was identified requiring the root-cause-analysis and quality improvement plan:

Performance Measure	MY 2020 (N)	MY 2020 (D)	MY 2020 Rate
FUH HEDIS 7-Day All Ages	6,815	14,838	45.93%

The following disparities with a statistically significant difference were identified among members with an IPMH admission:

- In the aggregate, the Black/African American cohort was less likely to have follow-up within 7-days compared to the White cohort.
  - This also applied to the Allegheny contract (HCAL), Berks contract (HCBK), Erie contract (HCER), Lycoming/Clinton contract (HCLC), and the York/Adams contract (HCYY).
- In HCBK, the White cohort was less likely to have follow-up within 7-days than members who selected Other or chose not to respond.
  - The drill down analysis concluded that of the 346 members with an inpatient mental health admission in HCBK, who fall under "other/chose not to respond" for race, 64% identified as Hispanic.
  - For the remaining 36% of members who fall under the "other/chose not to respond" for race, additional discerning demographics were unable to be identified.
  - Interventions developed to address all Community Care members will apply in this situation.
- In the North Central contract (HCNS),the Other cohort was less likely to have follow-up within 7-days when compared to the White cohort.
  - The drill down analysis concluded that HCNS members with an inpatient mental health discharge, who selected "other/chose not to respond" for race account for less than 100 individuals. These members were 2.6% of the contract's total discharges.
  - There were no additional discerning demographics identified for this population.

reports for accessibility of routine appointments, network availability, and assessment of cultural needs.

- Compilation of the Discharge Management Planning follow-up meetings that occurred with inpatient mental health providers in 2019.
- Information from Community Care's RCA submitted in 2020, 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.
- Review of current literature.

Attachments:
2018-19 Inpatient Barriers and Interventions
2021 HealthChoices Membership Analysis
2022 HCAL African American Target Analysis
Accessibility to Routine OPT and FU Report
Assessment of Cultural needs
BHARP County Input on Barriers from 2-14-22
BHARP Presentation Legislation Hearing 5 11 15
Network Availability Report
References

- Interventions developed to address all Community Care members will apply in this situation.
- In the aggregate, the non-Hispanic cohort with an inpatient mental health admission were less likely to have follow-up within 7-days than the Hispanic cohort.
  - This also applied to HCYY.

Community Care conducted a literature review and data analysis of Hispanic and non-Hispanic members with an inpatient mental health admission in 2020. Results are as follows:

- Among Community Care's HealthChoices enrollees, 89.1% identified as non-Hispanic (2021 HealthChoices Membership Analysis). When analyzed across contracts, the majority of members were non-Hispanic. For the contracts with a statistically significant difference in 7-day follow-up, the distribution of members identifying as non-Hispanic is as follows:

HCER	HCYY
93.8%	84.4%

- Literature reviews indicate that Hispanic individuals typically have lower rates of treatment engagement than non-Hispanic individuals. Community Care's Membership Analysis supports this hypothesis with only 14% of Hispanic enrollees engaging in services in 2020, compared to 22% of non-Hispanic members. However, further data analysis of HEDIS discharges between 2018 to 2020 indicate that Hispanic members in treatment are more likely to follow-up and remain engaged in treatment.
- Interventions developed to address all Community Care members will apply in this scenario due to the majority of our members falling in the non-Hispanic category.

Performance Measure: FUH HEDIS 7-Day All Ages
Rates with SSD

Contract	Cohort 1	Rate 1	Cohort 2	Rate 2
HC	Non-Hispanic White	46.3%	Hispanic, all Races	52.4%
HC	White	46.4%	Black/African American	41.9%
BK	White	42.9%	Black/African American	31.4%
BK	White	42.9%	Other/Chose not to respond	51.5%
ER	White	47.3%	Black/African American	34.5%

LC	White	40.5%	Black/African American	26.0%
YY	Non-Hispanic White	44.0%	Hispanic, all Races	58.7%

List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
People (1.1) Specific to Black/African American members Research shows 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	***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, 15.7% identified as African American (2021 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows:

HCAL	HCBK	HCER	HCLC	HCYY
37.6%	8.7%	19.8%	12.6%	13.5%

In 2020, 42% of the Black/African American members with an inpatient mental health admission had follow-up within 7-days. This is significantly less than White members in 2020, who had a 7-day follow-up rate of 46.4%.

Community Care's data analysis indicates that the inpatient length of stay of Black/African American members have an impact on the likelihood of aftercare. The inpatient mental health average length of stay for Black/African American members who had follow-up was 14.4 for 7-days, while the average length of stay for those who did not have follow-up was 8.8 days. In contrast, the average length of stay for White members was between 11.3 days, regardless of whether they had aftercare or not. 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. 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 (Centers for Disease Control, 2022). For 2016-2020, suicide was the second leading cause of death in Black children aged 10-14, and third for Black individuals aged 15-34 in Pennsylvania.

<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td></td><td>This factor is deemed critical.</td></tr>
<tr><td></td><td>Current and expected actionability:
Community Care has implemented interventions to specifically address disparities affecting our Black/African American population. The variance in follow-up between our White and Black/African American cohorts was 9 percentage points in 2019 to 5 percentage points in 2020. Further data is needed to determine if the improvement is artificial due to extraneous factors, more specifically the COVID-19 pandemic. This factor is expected to be actionable.</td></tr>
<tr><td>People (1.2)
Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues</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 information about barriers from inpatient mental health facilities through provider discussions and quality improvement plans. Specifically in 2019, Community Care conducted interviews with 8 inpatient mental health 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. Providers reported 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.
In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Transportation was identified as a barrier effecting members in rural communities.
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.
In 2020, Care Managers conducted Admission Interviews with 2,793 distinct adult members who were readmitted to an inpatient mental health or residential substance use treatment facility within 30 days. During interviews at the second admissions, members were asked if they were scheduled a follow-up appointment after the first admission, if they kept their follow-up appointment from the first admission, and if not, why. Fifty-nine percent of these members reported not keeping the follow-up appointment from the first admission. When asked why, 60% indicated they had a relapse in symptoms or readmission prior to the follow-up. The remaining 40% indicated the choice not to attend, forgot about the appointment, or needs related to transportation, legal status, housing, finances, or childcare.
In 2020, Community Care’s Care Managers also spoke with 672 members who did not attend aftercare to determine barriers. The most common responses for not attending were choice, vocational schedule, legal status, illness, transportation, technology, and housing.
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</td></tr>
</table>

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)	
	(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 inpatient setting. 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 (1.3) 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 inpatient mental health as part of the Admissions Interview activities which is described further in the interventions section. Specifically in 2020, Admission Interviews indicated that for readmitted adult members who did not attend aftercare appointments 33% did not have aftercare scheduled at discharge, while 11% reported difficulty with their medications as the reason for readmission, and 8% of adults indicated it was lack of timely follow-up from the first admission. Although members with readmissions are excluded from data for HEDIS follow-up, Community Care has access to barriers members are experiencing after an inpatient mental health 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. In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Unclear discharge instructions from inpatient mental health facilities is a barrier identified for members attending aftercare. 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 (1.4) 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 inpatient mental health 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. During barrier discussions, providers reported that members often decline aftercare. In 2020, Care Managers conducted Admission Interviews with 2,793 distinct adult members who were readmitted to an inpatient mental health or residential substance use treatment facility within 30 days. Of the members who had an aftercare appointment scheduled but did not attend, 17% indicated because

<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td></td><td>they chose not to. Furthermore, the Aftercare Outreach Care Managers spoke with 672 members in 2020 who did not attend their scheduled aftercare appointment and 14.4% indicated they declined to attend.
In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Member noncompliance is a barrier identified as impacting FUH.
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 inpatient mental health admissions. Due to these perceptions, individuals may decline aftercare when offered by inpatient 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.
This factor is deemed important.</td></tr>
<tr><td></td><td>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.</td></tr>
<tr><td>People (1.5)
Some members have competing physical health needs which makes setting up aftercare difficult</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 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 Care Management activities. According to an analysis of Integrated Care Plan activities (described further in the interventions section), 45% of the HEDIS qualified discharges in 2020 had an Integrated Care Plan, indicating a physical health need. Community Care also analyzed data captured through Admissions Interviews in 2021. There were 3,551 adult and 376 child interviews completed for members at inpatient facilities and 31.1% of adults and 10.1% of child members reported the inpatient mental health facility was actively helping them coordinate care for a medical condition.
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>
</table>

<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td rowspan="2">Providers (2.1) Specific to Black/African American members
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, 15.7% identified as African American (2021 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows:
<table>
<tr><th>HCAL</th><th>HCBK</th><th>HCER</th><th>HCLC</th><th>HCYY</th></tr>
<tr><td>37.6%</td><td>8.7%</td><td>19.8%</td><td>12.6%</td><td>13.5%</td></tr>
</table>
In 2020, of the 2,319 Black/African American members that had an IPMH admission, 41.9% had an appointment within 7-days. This is statistically significantly less than White members in 2020, who had a 7-day follow-up rate of 46.4%.
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 2021 Membership Analysis, Schizophrenia is the seventh most prevalent diagnosis among our Black/African American members in treatment, accounting for 6% of those members. This is compared to the White members in treatment, for whom Schizoaffective Disorder ranks tenth, accounting for 3% of those members. These are the only psychotic disorders among the ten most prevent for each cohort.
An analysis of the 2020 member level drilldown report, 34.2% of Black/African American members with an inpatient mental health admission were being treated for a primary diagnosis of a psychotic disorder (Schizophrenia, Schizoaffective Disorder, or Other Psychotic Disorder). In contrast, only 21.1% of White members were being treating for a psychotic disorder.
The 2020 drilldown also reveals that a total 1.33% (n.31) of Black/African American members had an inpatient stay of more than 100 days compared to .78% (n.88) of White members.
Of the 31 Black/African American members with an inpatient stay over 100 days, 26 (84%) were being treated for a psychotic disorder. For the White members 62 (70%) were being treated for a psychotic disorder. While conclusions cannot be made with these low numbers, there is a need to conduct more research.

This factor is deemed critical.</td></tr>
<tr><td>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.</td></tr>
</table>

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)	
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services	***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 2021 HealthChoices Membership Analysis, 11% of Community Care's members in treatment have an opioid use disorder and an additional 4% have an alcohol related disorder, placing them both in the ten most prevalent diagnoses for members in treatment. Of the 30-day follow-up appointments in our 2020 HEDIS sample, 2% were for Buprenorphine Services or Methadone Maintenance. Since this was the first appointment after inpatient mental health, we can assume this is not a new service for these members and there is likely another sample initiating medication assisted treatment services. Individuals with an opioid use disorder 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 opioid use disorder that includes medication assisted treatment is a contributing factor to delays in receiving treatment. Community Care feels that the ability to access medication assisted treatment and substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in medication assisted treatment or other substance use disorder treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen. Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). There were 3,551 adult interviews completed for members at inpatient mental health facilities in 2021; of those, 1,106 were interviews for members who had a previous inpatient admission in the past 30 days. When asked the reason for the readmission, 23.9% of adult members reported it was for substance use. For adult member interviews that were not a readmission (n. 4,172), 20.4% reported the reason for the inpatient mental health admission was substance use. This factor is critical.
	Current and expected actionability: Community Care has developed several interventions to assist members to access medication assisted treatment and substance-use treatment needs. We anticipate that we will continually make this a focus of company-wide activities.
Provisions (3.1) Specific to Black/African American members There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Community Care has goals set for ratios of members per provider meeting availability standards:

Physician	Psychologist	Non-Doctoral Level Therapist	Ambulatory Provider Organization
5,000:1	2,000:1	2,000:1	750:1

This data is calculated by distance to providers by members' home address. Our annual Network Availability report indicates that in August of 2021, Community Care was not currently meeting goal for Physician or Psychologist.

Community Care collects information from providers during credentialing and re-credentialing regarding voluntary disclosure of race (for private practitioners) and specialization working with minority populations (practitioners and facilities). Although not a direct comparison, we have data indicating the following:

Total Black/African American enrollees on 02/08/2022:	196,506

Total practitioners who voluntarily identified as Black/African American by category:

Psychiatrist	Psychologist	Masters Level
3	5	36

Ratio of practitioners who voluntarily identified as Black/African American by category per number of same-race enrollees:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1
65,502:1	39,301:1	5,459:1

Members: per provider

Ratio of practitioners and facilities who voluntarily identified as specializing in minority populations, specifically Black/African American minorities by category per number of same-race enrollees:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1	Facilities (MH OP Clinics, SUD OP Clinics, & FQHC/RHC) Goal 750:1
21,834:1	6,141:1	3,573:1	5,311:1

Members: per provider

As part of our 2021 RCA/QIP, Community Care developed a report to identify gaps in treatment

availability for Black/African American members using GEOAccess to plot geographical locations of provider service address and member's home address (described further in the interventions section). Allegheny County has the most Black/African American members by both proportion and whole number, compared to other contracts. Actually, Allegheny County has more Black/African American members than all other Community Care contracts combined. For this reason, the Targeted Accessibility Analysis report was applied to Allegheny County by breaking it into 4 quadrants to identify areas of Black/African American member density and available providers who are same-race or identify as specializing in Black/African American treatment.

Quadrant	Percent of Black/African American members under 18 meeting the access standard to culturally competent care	Percent of Black/African American members 18 & over meeting the access standard to culturally competent care
NE	38.2%	36.5%
NW	39.6%	42.6%
SE	40.0%	38.7%
SW	40.0%	40.1%
Urban Access Standard: 2 providers in 30 minute drive time		

Analyses have not been completed for the other contracts with a statistically significant disparity (HCBK, HCER, HCLC, or HCYY) between the White and Black/African American members due to the low volume of Black/African American members and providers who have voluntarily identified.

02/08/2022		HCBK	HCER	HCLC	HCYY
Total Black/African American Members		9,719	16,199	5,080	16,279
Proportion of Enrollees		8.7%	19.5%	12.9%	13.6%
Black/African American same-race providers	Psychiatrist	0	0	0	0
	Psychologist	0	0	0	0
	Master's Level	0	2	0	1
Specializing in minority populations: Black/African American	Psychiatrist	1	1	0	1
	Psychologist	2	2	1	2
	Master's Level	3	3	1	3
	Facilities	3	4	1	3

Based on this information, Community Care can reasonably deduce that the number of providers who are Black/African American or who specialize in this minority population do not meet the needs of our Black/African American members.

This is important because Black/African American individuals are more likely to trust and engage with Black or African American providers but less likely to find one (Evans, Rosenbaum, Malina, Morrissey, and Rubin, 2020). Historically Black individuals do not have adequate access to same-race treatment providers. In the United States, only 2% of psychiatrists identify as Black (Starks, 2021) and 4% of

psychologists (Healthline, 2021). This is crucial because Black and African American providers are known to provide more appropriate and effective care to Black and African American individuals (Mental Health America, 2021).
As this barrier will take time to address, The National Alliance on Mental Illness recommends that until the gap is closed it should be filled with culturally competent care. In order for a provider to be culturally competent, it goes beyond having a diverse workforce. Providers need to invest in gaining cultural knowledge of the populations they serve as it relates to help-seeking, treatment, and recovery (SAMHSA, 2014). Community Care's ability to gathering information on culturally competent providers is limited by the changing workforce. Staff turnover plays a significant role on the ability to maintain competency. 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 availability will continue to affect Community Care's ability to adequately address the actual root cause.

Provisions (3.2)
Medication appointments with psychiatrists are often hard to secure in a timely manner

Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Availability of psychiatrists has been an ongoing barrier to services in the State of Pennsylvania. Although Community Care consistently meets accessibility standards for Psychiatry, providers report difficulty getting individuals appointments with existing psychiatry time. In 2015 the Behavioral Health Alliance of Rural Pennsylvania did a point in time survey of psychiatric providers that indicated a need of double the psychiatric time currently available. This included the capacity of telehealth services and physician extenders at that time. Of the 14 surveyed providers, they are providing a 617 hours of psychiatric clinic time. Their study indicated a need for almost double the amount of current time being provided. While other services are available, psychiatry is essential for individuals with significant mental illness or serious emotional disturbances. Psychiatrists are often splitting their time between outpatient and other services, such as inpatient mental health, partial hospitalization, dual diagnosis treatment teams, etc.
A need for more psychiatric time seems to be a theme across the State. Community Care's annual Network Availability report indicates that in August of 2021, Community Care was not currently meeting goal for the enrollee to physician ratio of 5,000:1 with an actual ratio of 6,337:1. If we look at this analysis over time, we can see that although HealthChoices membership has grown, the number of Psychiatrist site's delivering the service has decreased.

Community Care contracted Psychiatrist by site count and ratio							
August 2018		August 2019		August 2020		August 2021	
Site Count	Ratio	Site Count	Ratio	Site Count	Ratio	Site Count	Ratio
216	4,538:1	208	4,783:1	205	5,515:1	191	6,337:1

In 2019, Community Care conducted interviews with 8 inpatient mental health 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. Specific barriers identified by these provides included "Psychiatry is hard to get" and Medication appointments are particularly challenging". Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). There were 3,551 adult and 376 child interviews completed for members at inpatient mental health facilities in 2021; of those, 1,216 were interviews for members who had a previous inpatient admission in the past 30 days. When asked the reason for the readmission, 17.1% of adults and 9.1% of children reported difficulty with their medications. This factor is deemed important.
	Current and expected actionability: Community Care has developed some interventions to work with current capacity but has a limited scope to address this barrier specifically.

Quality Improvement Plan for CY 2022

Rate Goal for 2022 (State the 2022 rate goal from your MY2020 FUH Goal Report here):

The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2021 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.

Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	**Admissions Interview:** The Utilization Management Children's and Adult High Risk Care Managers conduct longitudinal care management and outreach to high-risk members who encounter difficulties maintaining stabilization and community tenure. The Care Managers meet with these members at inpatient mental health facilities and substance use disorder treatment settings to provide face-to-face intervention, complete the interview tool to assess strengths/needs, and collaborate with the treatment team and inpatient staff to	Ongoing practice with process updated in 2020 Intervention occurs as part of the Care Management daily activities	Member needs reported in the Admissions Interviews, including those around physical health and medications, are regularly monitored through a Tableau Dashboard. Doing so allows Community Care to identify trends related to member needs and respond appropriately.

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	address aftercare planning, coordination, and reduce recidivism. In 2020, the readmission interview tool was expanded to include members with initial admissions and readmissions that do not meet the original eligibility criterion of readmission within 30 days. This expansion granted the opportunity for the intervention to serve as prevention. In addition, the high-risk care management intervention has been expanded to include children as well as individuals readmitted to substance use disorder treatment facilities. Also in 2020, many Admissions Interviews were completed virtually with members due to COVID-19 mitigation efforts.		
	In 2020 there were a total 2,934 adult and 58 child interviews were specific to inpatient mental health admissions. For members that had a completed Admissions Interview, 55.5% had 7-day HEDIS follow-up. This data suggests that members who received a complete Admissions Interview were significantly more likely to attend an aftercare appointment, specifically for the 7-day measure. To further support this finding, the 2019 7-day HEDIS follow-up rate for members who completed the Admission Interviews was 8 percentage points above our validated HEDIS rate.	2020	Community Care developed a monitoring report that was completed in late 2021 to pull information from the Admissions Interview template in the electronic record and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.
	Community Care Care Management Department monitors barriers to aftercare reported by members through this process on an ongoing basis through a Tableau Dashboard. In 2022, Community Care plans to add a racial and ethnic filter to the dashboard for contracts with disparities to routinely monitor and address barriers specifically identified by minority populations.	2022	
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers, providing education to members and providers, coordinating care, and assistance in aftercare planning.		
People (1.2) Many members have multiple barriers to	**Aftercare Outreach:** This intervention has evolved over time to best fit members' need. Community Care provides outreach to members who may be at risk. All members being discharged	Ongoing practice Intervention occurs as	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities.

<table>
<tr><th colspan="4">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td rowspan="3">attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues

People (1.3)
Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members

People (1.4)
Some members decline aftercare believing they don’t need it, will not benefit from it, or can’t overcome barriers associated with attending</td><td>from acute levels of care and who are not transitioned to another non-ambulatory service or placement receive follow-up to encourage adherence to a community-based aftercare appointment. The Care Manager will assist with problem solving and engaging the member to his/her aftercare appointment. If there is an Intensive Care Manager, Resource Coordinator, or Service Coordinator assigned, the Care Manager can contact the provider to ensure appropriate linkages for follow-up care.</td><td>part of the Care Management daily activities</td><td>Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.</td></tr>
<tr><td>In 2020, Community Care made Aftercare Outreach calls to 53% of our HEDIS Qualified Discharges and 13.4% were successful. An analysis of the data indicates that members who had a successful Aftercare Outreach call were 10-14% more likely to have timely follow-up.</td><td>2020</td><td rowspan="2">Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.</td></tr>
<tr><td>Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.</td><td></td></tr>
<tr><td>People (1.5)
Some members have competing physical health needs which makes setting up aftercare difficult</td><td>Allegheny Care Management Team: (HCAL) The Integrated Care Team assists Allegheny County Health Choices members, families, health plans, and providers in facilitating coordination of physical health/behavioral health care. The team advocates for members with the four physical health managed care organizations serving Allegheny County and provides behavioral health history, referrals, and direct provider and member outreach. The physical health managed care organizations receive daily internal referrals from care managers on Community Care child and adult teams for members with physical health needs and obtain member consents for enhanced coordination of care. The team provides training regarding physical health/behavioral health integration to</td><td>Ongoing practice

Intervention occurs as part of the Care Management daily activities</td><td>Monitoring for the needs identified occurs on an ad hoc basis through Clinical Supervision.</td></tr>
</table>

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
	behavioral health providers and member/community groups and supports multiple UPMC care coordination initiatives. Their established relationships with health plans and providers promote a 'whole health' collaborative approach.		
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services	**Centers of Excellence:** The Pennsylvania Department of Human Services launched the Centers of Excellence in 2016 to expand access to medication assisted treatment and other effective treatments. Centers of Excellence are licensed substance use disorder treatment providers that provide counseling, methadone, buprenorphine, or naltrexone assisted treatment. Centers of Excellence offer members diagnosed with an opioid use disorder peer support throughout all stages of recovery as well as Care Management to assist members in identifying, receiving, and sustaining treatment. Community Care's Care Management team helps individuals with opioid use disorder navigate the health care system by facilitating initiation into opioid use disorder treatment from emergency departments and primary care physicians; helping individuals transition from inpatient levels of care to ongoing engagement in community-based treatment; and facilitating transition of individuals with opioid use disorder leaving state and county corrections systems to ongoing treatment within the community.	Centers of Excellence initiated in January 2017 and enrollment began July 2019. Activities around this initiative remain ongoing.	Regular data reviews now occur by Community Care to ensure that Centers of Excellence thrive over time and feedback webinars continue to occur monthly with providers, though the live format has been suspended during the COVID-19 crisis; the feedback now includes slides that are updated monthly and emailed to all agencies and county stakeholders. Additionally, Community Care created a range of telehealth documents for medication assisted treatment providers, including the Centers of Excellence, which are posted on Community Care's website (https://providers.ccbh.com/COVID-19-info/providing-treatment).
	Community Care reviews data metrics related to Centers of Excellence on a quarterly basis. Information reviewed includes length of stay, type of medicated assisted treatment, diagnosis, category of enrollment, and gender. Additionally, in February 2021, Community Care added race and ethnicity data to the to the monitoring. In 2021, the Department of Human Services expanded this program beyond the original 45 agencies to increase access and capacity. By September 21, 2021 there were 240 Centers of Excellence locations reflecting at least 61 unique organizations in Pennsylvania. Over 40 Centers of Excellence in Community Care's network have actively submitted claims. Enrollment	2021	

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	started in July 2019 and as of December 2021, a total of 11,737 Community Care members have enrolled in a Center of Excellence. In the 2021 calendar year alone, 8,866 unique Community Care members received at least one Centers of Excellence claim. There are 5 types of Centers of Excellence in our network; Opioid Treatment Programs, Substance Use Disorder - Outpatient, Residential and Outpatient Programs, Single County Authorities, and Office Based Opioid Treatment. The vast majority (August 2021, 72%) of Community Care members in Centers of Excellence are enrolled in an Opioid Treatment Program.		
	Community Care will be collaborating with the University of Pittsburgh Program and Evaluation Research Unit and the Department of Human Services to develop a series of standard algorithms for calculating enrollment, engagement, and retention rates for use by Centers of Excellence and managed care organizations.	2022	
	Community Care feels that the ability to access medication assisted treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health facilities. Members being enrolled in medication assisted treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		
Providers (2.2) *Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment service**s***	**Certified Assessment Centers -** (HCAL) The Certified Assessment Centers program was developed in 2019 and implemented in 2020 in Allegheny County with four providers. Certified Assessment Centers are designed to ensure timely access to substance use services of Allegheny County residents' choice and based on results of their level of care assessment. The purpose of the Certified Assessment Centers is to provide timely (within 48 hours) level of care assessments for substance use disorders, offer referrals and warm handoffs to appropriate substance use services and supports, reduce obstacles to initiating treatment, and ensure treatment is initiated. All clients are offered options of their choice for providers who would deliver the recommended level of care, and direct admissions are expected to occur. The PA Get Help Now Hotline	2020 – Present Ongoing	Allegheny County Department of Human Services is partnering with Community Care to align and enhance reporting with identified measures, including level of care admissions within 14 days of level of care assessments completion, completion of a level of care assessments within 48 hours of request from any source, attendance at all required provider meetings, and submission of timely data reports. The value-based payment arrangement for Certified Assessment Centers is anticipated to

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	and providers triage referrals to Certified Assessment Centers, who provide level of care assessments and facilitate further linkages to appropriate substance use disorder treatment providers. In 2021, a value-based payment arrangement will be implemented with Certified Assessment Centers to promote timely access to level of care assessments and increase timely linkage to substance use disorder services.		begin implementation in July 2021.
	Community Care feels that the ability to access substance use disorder treatment affects our members' recovery and will likely impact the follow-up of our co-occurring members from inpatient mental health.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Collaborative Care at Federally Qualified Healthcare Centers:** (HCAL, HCNE, HCYY, HCBK, HCCH, HCCK) Community Care believes that implementing Collaborative Care to integrate primary care and behavioral health is a clear remedy for many of these problems with co-morbid conditions. Based on principles of effective chronic illness care, Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained Primary Care Physicians, and embedded Behavioral Health Practitioners provide evidence-based psychosocial treatments and/or medication, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. The model consistently results in improved patient and provider satisfaction, improved functioning, and reductions in health care costs, achieving the Triple Aim of health care reform.	Ongoing practice	Federally Qualified Health Centers are a primary focus for the Director of Integration and monitoring activities occur on a regular basis. Community Care hosts quarterly Provider Meetings with Federally Qualified Healthcare Centers, of which data metrics are a routine topic.
	Community Care currently has 27 Federally Qualified Health Center providers at 94 locations throughout the network. In 2021 Community Care partnered with Pennsylvania Association of Community Health Centers to invite all Federally Qualified Health Centers across Pennsylvania to participate in a Learning Community to focus on increasing the utilization of Collaborative Care and engagement in substance use disorder treatment with increasing rates of medicated assisted treatment for alcohol use disorders and opioid use disorders within Federally Qualified Health Centers . A total of 14 different providers participating in some or all of the sessions.	2021	

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	As part of the Learning Community, which was active June - November, 2021, Federally Qualified Health Centers were asked to provide substance use disorder screening information. This information found that the number of screenings increased over time, more individuals with alcohol use disorder or opioid use disorder were identified, the number of individuals receiving brief intervention for alcohol use disorder and opioid use disorder increased, and most importantly, the number of individuals treated for alcohol use disorder and opioid use disorder at the Federally Qualified Health Centers increased over time.		
	Community Care has implemented a joint value-based purchasing arrangement with UPMC for You. Six Federally Qualified Health Centers were offered the opportunity participate in the value-based purchasing arrangement (five in Allegheny County; one in York County). The value-based purchasing arrangement includes physical health and behavioral health metrics. This is the first combined physical Health/behavioral health value-based purchasing activity that Community Care has undertaken. The value-based purchasing arrangement started April 1, 2021 and will run for one year. Goals for this value-based purchasing arrangement are to improve tobacco screening, tobacco cessation, depression screening, and antidepression medication adherence.	April 1, 2021 - March 31, 2022	Monitoring for this intervention is driven by value-based purchasing arrangements. Quarterly Meetings occur to update providers on the metrics.
	Community Care plans to build on the success of the Learning Community by hosting 4 Quarterly Federally Qualified Health Center Collaborative Care meetings in 2022 with a continued focus on expanding the usage of the Collaborative Care model and increasing screening and interventions for individuals with substance use disorders.	2022	During the 2022 Federally Qualified Health Centers Collaborative Care meetings, Community Care will facilitate open discussions around expanding the usage of Collaborative Care and increasing screenings and treatment.
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
People (1.2) Many members have multiple barriers to attending aftercare like	**Community Based Care Management:** Community Based Care Management is a new Care Management program aligning with the Department of Human Service's initiatives around whole-person healthcare reform. Elements of this program include:	2020 - Planning phase	Community Care has a Data Analytic staff specific to this program. In 2022, this staff will assist with providing data of members supported by Community

transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending ***People (1.5)*** Some members have competing physical health needs which makes setting up aftercare difficult	• Enhancing care management activities in the community by working directly with members and providers; • Enhancing physical and behavioral health coordination to address whole person health and wellness; • Decreasing unplanned, emergent admissions; • Increasing access to healthcare; • Enhancing crisis and substance use disorder services; • Screening members for Post-Partum Depression; and, • Screening of social determinants of health and linking members to services and resources. **Community Health Workers** are an integral part of this program and are responsible for completing face to face or telephonic admission and readmission interviews with members to identify barriers to services and resources and to plan for aftercare, advocating for person centered treatment and aftercare planning, participating in interagency and collaboration meetings with providers and members, providing ongoing follow up and support by meeting with the member in the community at provider sites and in the member home, completing warm hand offs to community resources and providers, following up with members who identify social determinant of health challenges during Customer Service New Member Welcome Calls and Post Discharge Outreach Calls, supporting the Community Based Organizations with identifying Community Care members, ensuring coordination with current Behavioral Health Providers, and assisting to link members to Behavioral Health services. Community Based Care Management also includes the use of **Pre/Post Natal Care Managers** who outreach to, engage, assess, and link members during pregnancy and post-delivery or end of pregnancy, who have an identified behavioral health need. The Pre/Post Natal Care Manager coordinates with the physical health managed care organizations to link the members to prenatal care and resources, as well as to transfer members to the physical health managed care organizations' maternity programs if there are no identified behavioral health needs.		Based Organizations, Care Manager and Community Health Worker interventions, and outcomes related to use of emergent and community-based services.

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	Community Based Care Management allowed Community Care the opportunity to partner with and provide funding for staff and administrative costs to **Community Based Organizations**. The Community Based Organizations provide services and resources which address social determinants of health the greatly impact the HealthChoices members.		
	In 2021, Community Care hired additional internal positions to expand and enhance the community work that is done to support members. Blair, Bedford/Somerset, and Lycoming/Clinton contracts opted to utilize existing positions either within Community Care, county partners, or the HealthChoices teams to absorb some of the Community Based Care Management responsibilities. New positions included Community Health Workers and Pre/Post Natal Care Managers per specific contracts, and a Data Analytics position shared amongst all contracts. Community Care contracted with 24 Community Based Organizations in 2021 and 1 contracted directly with Blair HealthChoices. Community Based Organizations were chosen by determining the greatest social determinate of health that impacted the community and then contracting with an agency that addressed those barriers. Examples of Community Based Organizations ranged from emergency shelters and transitional housing to local United Way and Community Action organizations.	2021- Development phase	
	In 2021, Community Health Workers engaged with 657 unique members and completed a total of 4,188 in person or phone contacts or attempts with members, Pre/Post Natal Care Managers engaged with 1,065 members, and Community Based Organizations have supported 3,420 members.	2021-2022 – Implementation phase	Community Care is engaging the Research and Outcomes Team to help build a foundation for future outcomes reporting.
	Community Care will continue to explore increasing and identifying new opportunities for community engagement with members, providers, and Community Based Organizations, while also adhering to COVID 19 protocols and guidelines.		
	Community Care believes that this intervention will improve aftercare through the activities of Community Based Care Management, which includes encouraging the use of preventative services, mitigating social determinants of health		

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	barriers, reducing health disparities, improving behavioral health outcomes, and increasing partnerships with Community-Based Organizations.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Community HealthChoices:** Community HealthChoices is Pennsylvania's mandatory managed care program for dually eligible individuals (Medicare and Medicaid) and individuals with physical disabilities. Community HealthChoices was developed to enhance access to and improve coordination of medical care as well as to create a person-driven, long-term support system in which individuals have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. Community HealthChoices implementation officially completed with the last phase starting January 2020. All zones are now active with Community HealthChoices. There are regular meetings with the 3 Community HealthChoices plans across Pennsylvania to identify challenging cases, barriers, training and information/resource sharing. These continued collaboration activities are led by Community Care's Director of Integration.	Community HealthChoices implemented January 2019 - January 2020 Community HealthChoices coordination occurs as part of the Care Management daily activities	Community Care hosts and participates in quarterly statewide partner meetings with the other Community HealthChoices managed care organizations in Pennsylvania to identify challenging cases, barriers, training, data sharing, and information/resource sharing. Community Care collaboratively shares information regarding 7-day follow up and inpatient admissions with Community HealthChoices. Likewise, data is shared with us regarding physical health data.
	There are currently 144,650 Community HealthChoices members receiving behavioral health services. In 2020, the monthly inpatient mental health utilization of Community HealthChoices fluctuated between 145 and 260 members per month. In fact, Community HealthChoices members accounted for 15% of Community Care's HEDIS qualified discharges. Data analysis indicates that HEDIS follow-up of our Community HealthChoices members is about 8 percentage points below the aggregate.	2020	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.
	This data was analyzed to determine barriers related to Community HealthChoices members receiving timely aftercare following an inpatient mental health admission. Community Care identified the following factors to decreased FUH rate in Community HealthChoices members: • Aftercare services are not billed through Medicare as the members' primary insurer, • Many older individuals receive behavioral health services through primary care, and, • Many Community HealthChoices members have		

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	existing home and community services. To support these findings, Community Care was able to access some Community HealthChoices Medicare data to evaluate the penetration of behavioral health services with both payers (Medicaid and Medicare) combined. In 2020, Community HealthChoices members in Allegheny County had a penetration rate of 11% when only analyzing Medicaid claims. When Medicare claims were added, 61% of Allegheny Community HealthChoices members had a behavioral health claim.		
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care. Unfortunately, Community Care's ability to impact our HEDIS FUH rate for Community HealthChoices is limited due to dual eligibility factors.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services	**Co-Occurring Disorder Initiative –** (HCAL) Allegheny County Department of Human Services, Allegheny HealthChoices Initiative, and Community Care, in close collaboration with Case Western Reserve University's Center for Evidence-Based Practices, established the Co-Occurring Disorders Initiative in Allegheny County in 2015 to increase ambulatory providers' competencies with co-occurring disorder treatment within the existing administrative and regulatory structures. The Dual Diagnosis Capability framework for Mental Health Treatment and Addiction Treatment guide the initiative, which includes a baseline Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment assessment, quality improvement planning, technical assistance, training, and provider meetings to discuss progress.	2015 – Present Ongoing, Quarterly	To monitor progress with co-occurring disorder capability, providers share updates during the quarterly provider meetings and discuss successes and challenges in further detail during technical assistance sessions. Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment re-assessments are completed upon request to monitor direct changes in provider competencies.
	In 2022, participating outpatient programs have the opportunity to earn an enhanced rate on relevant billing codes for two years for achieving identified thresholds of co-occurring treatment capability. The purpose of this process is to further incentivize and support quality improvement of ambulatory services in their capacity to serve individuals with co-occurring mental health and substance use disorders concurrently. Eligibility for the enhanced rate is based on scores on a new	2022	

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	Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment. Five programs across four providers (four outpatient substance use, one outpatient mental health) made the decision to undergo the review process in 2022.		
	Community Care feels that the ability to access co-occurring disorder treatment affects our members' recovery and directly and indirectly impacts the follow-up of our co-occurring members from inpatient mental health.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	**Enhanced Discharge Planning:** Daily Care Management activities focus on members with readmissions and involves review of daily admissions (Care Management reviews on Monday include weekend admissions.) Care Managers conduct a semi-structured interview, using motivational approaches, problem solving, and case management follow-up activities to ensure members received needed aftercare.	Ongoing Intervention occurs as part of the Care Management daily activities	During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time, as needed, with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments as well as presented at the Care Management Leadership meeting. Care Management interventions are targeted and adjusted, as necessary, per the data.
	In October 2019, Community Care expanded the interview process. Interviews now include children as well as other priority members, for example, members who may have readmitted over the standard 30-day readmission timeframe (i.e., readmitted after 35 days) or who may have other barriers related to other social determinants. This expansion may grant opportunity for this intervention to serve as prevention. In February 2020, Community Care further expanded the interview process to include members who were admitted for the first time to an IPMH. Also, 3.5 and 3.7 levels of care were added for the interviews. All contracts used the same readmission interview template to identify reasons presenting for admission and to assist in discharge planning.	Process expanded in October 2019 and again February 2020	
	During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time, as needed, with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments as well as presented at the		Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.

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	Care Management Leadership meeting. Care Management interventions are targeted and adjusted, as necessary, per the data.		
	Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	**High-Risk Care Management interventions:** Members can be deemed high risk for reasons such as clinical presentation, treatment history and response, or as an identified at-risk population. High-Risk members require a longitudinal intensive level of intervention. Comprehensive Care Management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of High-Risk care management. High-Risk Care Managers met with members face-to-face on the unit to identify these barriers, address concerns, coordinate with inpatient staff around member needs, and help with discharge planning. Starting in March 2020, due to concerns surrounding the COVID-19 pandemic, Care Managers implemented both telephonic or virtual interviews to capture the data and intervene, as necessary. High-Risk Care Managers encourage coordination with family or friends as part of their interaction with members. High-Risk Care Managers address social determinants with the member and the inpatient staff and coordinate with relevant agencies during the inpatient stay.	Ongoing Intervention occurs as part of the Care Management daily activities	Clinical Supervisors utilize a standardized tool to rate Care Managers related to interventions performed with members. This template includes a question related to follow-up ("The Care Manager review shows evidence of robust discharge planning, for example awareness of factors leading to readmission and/or potential triggers for readmission"). Feedback and corrective actions are taken with care managers, as necessary.
	In 2021, Community Care developed High-Risk Care Management Best Practice Guidelines to aid in standardization of High Risk practices.	2021	
	Community Care uses clinical groupings to identify members who are receiving enhanced care management activities such as High Risk or Complex Care Management. Data analysis of the 2020 HEDIS FUH data indicates that members who were in these clinical groupings were 9 to 10 percent more likely to have follow-up within 7-days. At this time, we are considering this data preliminary as Care Managers were not always consistently using the clinical grouping to identify members	2021	Community Care developed an RCA Monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional

<table>
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<tr><td></td><td>receiving these interventions. We believe that the data for 2020 does not reflect all the possible members who were receiving these enhanced interventions.
In 2021, Care Managers were asked to consistently use clinical grouping selection to identify members with enhanced Care Management interventions. A report was developed for Care Management to track the consistency of the selection and a job-aide was developed.</td><td></td><td>opportunities for improvement.

Specific to Care Management consistently using clinical groupings, this report is reviewed by and updated on a monthly basis.</td></tr>
<tr><td></td><td>Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.</td><td></td><td></td></tr>
<tr><td>People (1.3)
Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members</td><td>Inpatient Mental Health Provider Quality Improvement Activities: Community Care conducted its annual review of the entire inpatient mental health provider network on February 21, 2021, and based on this review, six distinct providers were selected to participate the 2021 Inpatient Mental Health Quality Improvement Activity. Community Care’s Inpatient Mental Health Quality Improvement Activity process has typically been composed of staff interviews, a facility tour, discussion with executive leadership staff, and the completion of member record reviews. However, given the current COVID-19 pandemic and increased restrictions across the state, Community Care’s Quality Department made modifications to this year’s 2021 Inpatient Mental Health Quality Improvement Activity methodology with the suspension of onsite activities; record reviews were completed via mail, secure email, fax, or remote electronic medical record; facility tours were not completed but staff interviews were done virtually. During a record review, if a provider did not score within the designated benchmark for the Discharge Management Planning composite score, which includes “Follow-up appointment scheduled within 7 days, including all required elements,” a Quality Improvement Plan would be requested from the provider.</td><td>This process was implemented in March of 2019 as an annual activity. Prior to 2019 inpatient mental health activities occurred on a contract specific schedule.</td><td>Each year’s activities are reviewed at the Board Quality Improvement Committee and each contract's Quality and Care Management Committee meetings.</td></tr>
<tr><td></td><td>Update to review results are as follows.
Indicator: Notice to aftercare providers within 1 business day of inpatient discharge including information about discharge and medications
<table>
<tr><th>2019 Rate</th><th>2020 Rate</th><th>2021 Rate</th></tr>
<tr><td>69%</td><td>73%</td><td>70%</td></tr>
</table></td><td>2021</td><td>This is an annual activity that will be completed again in 2022.</td></tr>
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<tr><th colspan="4">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td></td><td>Indicator: Evidence of a Completed Discharge Management Plan
<table><tr><th>2019 Rate</th><th>2020 Rate</th><th>2021 Rate</th></tr><tr><td>96%</td><td>100%</td><td>95%</td></tr></table>
Indicator: Follow Up appointment scheduled within 7 days, including all required elements
<table><tr><th>2019 Rate</th><th>2020 Rate</th><th>2021 Rate</th></tr><tr><td>69%</td><td>91%</td><td>80%</td></tr></table>
For record review indicators around discharge planning, the composite score was 85%.
Providers who did not meet goal for any record review indicator were asked to complete a quality improvement plan. This resulted in all 6 providers submitting a quality improvement plan for the 2021 Inpatient Mental Health Quality Improvement Activities.

Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, addressing engagement issues, and physical health needs.</td><td></td><td></td></tr>
<tr><td>People (1.5)
Some members have competing physical health needs which makes setting up aftercare difficult</td><td>Integrated Care Plan: In alignment with Pennsylvania Department of Human Services goal for greater integration and coordination of behavioral and physical health services, Community Care engages in care coordination with physical health plans and documents these activities in an Integrated Care Plan. This Integrated Care Plan, or member profile, is used for the collection, integration and documentation of key physical and behavioral health information that is easily accessible.
Community Care identifies members for inclusion in the project based on diagnostic history. Members are stratified to either high or low behavioral health need using a Community Care defined algorithm. The behavioral health stratification file is shared with corresponding physician health plan. The physical health plan adds their physical health high/low stratification completing the 4-quadrant analysis. Combined behavioral</td><td>Ongoing

Intervention occurs as part of the Care Management daily activities</td><td>The number of completed Integrated Care Plans is tracked and presented annually to the Quality and Care Management Committees. Goals related to Integrated Care Plans completed have been consistently met.
As part of the activity, Community Care monitors Integrated Care Plans completed for members with an inpatient admission. The measurements around this activity focus on integrating physical and behavioral health care.</td></tr>
</table>

	health/physical health member file is returned to Community Care. Process completed monthly to capture new, changed or deleted information. Data is uploaded to our clinical platform on the Integrated Care Plan Template; the electronic template documents the member's physical health and behavioral health needs, dates of coordination with respective plan, referral reason and intervention. The template is completed primarily following telephone coordination with the physical health plan representative, either ad hoc or during planning clinical rounds Care managers will have the ability to view the members' tiers on the Clinical Group tab.		
	Community Care's goal for each contract is 0.42% of the 2017 averaged monthly Medicaid eligible will have an Integrated Care Plan including physical health and behavioral health data reviewed by both managed care organizations. The number of completed Integrated Care Plans is tracked and presented annually to the Quality and Care Management Committees. Goals related to Integrated Care Plans completed have been consistently met. Of note, there were 8,494 Integrated Care Plans completed in 2021.	2017-2021	
	According to an analysis of the 2020 HEDIS FUH data, 45% of HEDIS qualified discharges had an Integrated Care Plan. The follow-up rates for these members were 2 percentage points higher for 7-day.	2020	
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***Provisions (3.2)*** Medication	**Inpatient Mental Health Shared Savings Value-Based Payment Arrangement:** Community Care and its primary contractors implemented a shared savings value-based payment model for inpatient mental health facilities focused on 7-day ambulatory follow-up and 30-day readmission. While those two areas of focus improve community tenure and encourage treatment in the least restrictive care for our members, reduction of readmission reduces the per cost per member for care. These efforts result in not only better outcomes for members but also allow for savings dollars to be shared back with inpatient	Initiated in January 2017, ongoing growth and development.	Monitoring for this intervention is driven by value-based purchasing arrangements. Measures are 7-day follow-up rate and 30-day readmission rate. So far, the provider's success in meeting goals related to follow-up have not been consistent. Ongoing activities related to Value-Based Purchasing arrangements are

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
appointments with psychiatrists are often hard to secure in a timely manner	mental health facilities. Providers' meeting goals on the measures receive a portion of the savings in the form of a rate enhancement in the future year.		occurring as expected and will continue within Community Care, with providers given performance reports via Community Care's portal on a monthly basis. Payments to providers are made according to performance.
	Inpatient mental health value-based purchasing activities with analyses in 2021 consisted of 8 inpatient providers. All 8 providers met the goal for 7-day follow-up. There were 44 measures (8 providers measured for multiple contracts) analyzed in 2020 for 7-day follow-up and 6 met the goal.	2020 & 2021 Analyses	
	Transition to Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement: In 2021, the Inpatient Mental Health Shared Savings model evolved into a shared savings model that includes the ambulatory services system and focuses on the successful transition from inpatient to ambulatory services and the coordination of the two service systems to maintain members in the community. Activities included a Learning Collaborative for providers to increase collaboration and knowledge of best practices at both levels of care. Measures will include 30-day readmission and 7-day follow-up, but providers will also be required to participate in regional collaborative activities. This Value Based model will also include a community-based organization in the region that will address social determinants of health that impact members being admitted or have the potential to be admitted to inpatient mental health services.	2021	Community Care believes that the addition of ambulatory services and evolvement into a shared savings model will encourage providers to be more proactive about actively addressing barriers to aftercare. Rates will be analyzed for follow-up again in 2021 to evaluate effectiveness.
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, aftercare, and addressing engagement issues.		
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to	**Mental Health First Aid–** (HCAL) Allegheny HealthChoices Initiative and Allegheny County Department of Human Services collaborate to facilitate the Southwestern Pennsylvania Mental Health First Aid Collaborative, which was founded in 2009 to maximize the positive impact of Mental Health First Aid trainings in Allegheny and surrounding counties. Mental Health First Aid is an evidence-based public education program that trains individuals to be able to recognize and provide initial support to those who may be experiencing early, worsening, and crisis-level mental health and substance use challenges.	2009 – Present Ongoing	Allegheny HealthChoices Initiative maintains a database related to Southwestern Pennsylvania Mental Health First Aid Collaborative trainings and facilitates additional data requests to the National Council for Behavioral Health, the organization that houses Mental Health First Aid program in the United States. Outcomes related to Mental Health First Aid training are

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
negative perceptions of treatment and reluctance to acknowledge symptoms ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	The training has been tailored to meet the needs of several populations, including adults learning how to assist other adults (Adult Mental Health First Aid) and adults learning how to assist youth (Youth Mental Health First Aid). Trainings can occur in-person, virtually, or in a blended capacity. The Southwestern Pennsylvania Mental Health First Aid Collaborative consists of over 190 certified Mental Health First Aid instructors from over 80 organizations, including Steel Smiling, Allegheny County Department of Human Services Offices, and a range of behavioral health and social services providers. Trainings are held for members of diverse communities and organizations in Allegheny County, including areas with majority Black/African American populations and community organizations serving those communities. Allegheny HealthChoices Initiative coordinates regional instructor certification trainings and Mental Health First Aid trainings for HealthChoices members and those who serve them, in addition to other populations through other funding sources, such as the SAMHSA Emergency Response Grant.		provided upon request, including the number of trainings held by type, number of participants trained, and number of trainers.
People (1.1) Specific to Black/African American members Research shows 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 ***Providers (2.1) Specific to Black/African American members*** Black and African	**Minority Benchmarking Workgroup:** (HCAL) In 2020 Community Care developed a Minority Benchmarking Workgroup to identify and address disparities in Substance Use Disorder Treatment. The workgroup started with Allegheny County, as Community Care's most diverse contract, with the goal of developing interventions that can be replicated in other contracts. The workgroup found that in Allegheny County Black or African American members are less likely to receive Medicated Assisted Treatment as a treatment.	2020 and ongoing	This workgroup meets monthly to discuss data and finding.
	The Minority Benchmarking Workgroup is proposing interventions that focus on outpatient substance use treatment providers and increasing the percentage of minority members on medicated assisted treatment through education.	2021-2022	Once interventions are finalized in conjunction with stakeholders, the workgroup will develop a method to track and report outcomes for the project.
	Proposed interventions to be reviewed with Allegheny County and Allegheny HealthChoices, Inc. for consideration and feedback.	2022	
	Community Care feels that the ability to access medication assisted treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from		

Americans experience health inequity in behavioral health treatment	inpatient mental health facilities.		
People (1.1) Specific to Black/African American members Research shows 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 ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience health inequity in behavioral health treatment ***Provisions (3.1) Specific to Black/African American members*** There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally	**Network Availability of Black/African American practitioners and culturally competent providers:** Community Care asks practitioners if they would like to disclose their race/ethnicity or religion to be used during our referral process, and all providers are asked if they have any area of specialization during the credentialing and re-credentialing process. Providers who choose to disclose this are identified within Community Care's network accordingly. When members call Community Care's Member Line requesting same-race practitioners or practitioners specializing in minority populations, Customer Service Representatives are able to see this information when searching for providers in the member's region.	Ongoing	Community Care will track the number of practitioners and facilities disclosing a specializing in minority population and practitioner race/ethnicity/religion through multiple projects occurring around network availability. These factors are consistently assessed when considering network expansion.
	In 2021, Community Care surveyed the provider network, encouraging the disclosure of race, ethnicity, religion, or specializations to improve the accuracy of information. As of February 2022, 70% of Community Care's contracted practitioners who have gone through recredentialing (3 year cycle) identified their race. Of the 70% (675) who self-identified 7% (44) identified as Black or African American. Race/ethnicity and religion are not tracked for facility credentialed providers, as this information is dependent on who is employed by the facility at the time of credentialing and is subject to change. For specializations, 96 practitioners and 37 facilities responded to having specialized knowledge and cultural competency in the Black/African American population.	2021	Updates for this intervention will be kept by Community Care's Network Department to ensure movement and reportability.
	This information is not available on the Provider Directory at www.ccbh.com. Community Care will explore the option of adding this information to applicable providers in the Provider Directory with possible search capabilities when and if a method for directory updates is established to improve accuracy. Community Care will continue to work with providers to get	2022-2023	

competent care	race, ethnicity, language, and specialization information during the credentialing and re-credentialing process to have the most accurate information as possible in order to assist members in finding culturally competent care.		
	Community Care feels that it is essential for members to receive culturally competent care. Encouraging providers to disclose race, ethnicity, and/or specialization(s) assists members to make informed decisions when choosing a treatment provider. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services ***Provisions (3.2)*** Medication appointments with psychiatrists are often hard to secure in a timely manner	**Network Expansion:** Community Care is continually seeking to expand the network, as appropriate, to best meet the needs of members. Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Community Care's Network Department adds providers to the network that offer non-traditional hours when they are available. Community Care also collaborates with providers within the existing network to ensure after-hour appointments are offered and accommodated. Emphasis for non-traditional hours have been given towards medication assisted treatment providers. Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule.	Ongoing part of operations	Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Emphasis for non-traditional hours have been given towards medication assisted treatment providers. Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule. Community Care also monitors all complaints that may be related to a provider's unwillingness to accommodate a member's schedule. Each complaint is investigated thoroughly, with a focus on the member receiving the services, as necessary.
	In 2021, various network expansion occurred, including the addition of new providers and expansion of existing providers through additional locations and levels of care such as: • Inpatient Mental Health • Residential Substance Abuse treatment • Individualized Behavioral Health Services • Telepsychiatry • Clozaril Support	2021	
	Community Care feels this intervention has a positive impact on HEDIS FUH rate by improving the availability of appropriate levels of care and provider options following an inpatient		

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
	mental health discharge.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Outpatient Mental Health Quality Record Reviews:** Community Care conducts Record Reviews for ambulatory providers when these levels of care are identified as a contract priority and planned in the annual Quality Work Plan. One of the indicators often assessed during these reviews is "If member had an inpatient mental health admission during the course treatment, post-hospital follow-up occurs within 7 calendar days." Providers with a sufficient sample who do not meet goal are asked to complete a quality improvement plan on how to improve.	Annual, as determined by each contract's Quality Work Plan.	Each year's reviews are reviewed at each contract's Quality and Care Management Committee meetings.
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers for providing timely follow-up.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Performance Issues:** Community Care tracks aftercare appointments from all inpatient discharges as part of routine Care Management functions. The Quality Management Department collates this data to determine if members have aftercare appointments prior to discharge and that those appointments are within 7-days of the discharge date. The data is monitored on a monthly basis and providers who develop a trend of provider performance issues, a quality improvement plan is requested, and the trend is monitored for resolution. This intervention applies to both inpatient and aftercare service providers.	Suspended	Community Care's Quality Management Department reviews Provider Performance Issues on a monthly basis to track and identify trends. Quality Improvement Plan requests, update requests, or notifications are sent on a monthly basis based on multiple factors, including length of trend, past trends, or past requests.
	Additional information on Provider Performance Issues can be found on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/information-and-resources/provider-performance-issues		
	This activity has been suspended since May 2020 due to COVID-19. Community Care will resume this intervention when OMHSAS lifts the temporary suspension of specific authorization regulations, (bulletin 1135).	This activity has been suspended since May 2020 due to COVID-19. Community Care will resume this intervention when OMHSAS lifts the temporary suspension of specific authorization	
	Community Care feels that this intervention impacts our HEDIS follow-up rates by addressing deficiencies at the provider level.		

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
		regulations, (bulletin 1135).	
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Performance Standards:** Community Care issues Performance Standards which are intended to be best-practice standards that providers will use to design and assess their programs and that Community Care will use to assist with assessment of the quality of services. Performance Standards are published for providers on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/performance-standards Community Care has issued Performance Standards specific to inpatient and outpatient levels of care which outlines expectations around aftercare planning and aftercare appointments. Community Care feels that establishing performance standards supports interventions by clearly outlining the expectation of timely follow-up in documents regularly shared with the provider.	Ongoing and updated in 2019	Community Care directs providers to the Performance Standards, and/or distributes copies of performance standards as part of many company activities, as appropriate, such as provider meetings, requests for quality improvement, and during credentialing. Community Care's Quality Management Department conducts scheduled and ad hoc record reviews of provider records to assess adherence to Performance Standards. Indicators around discharge planning are included in tools for all levels of care and rates are compared over time in annual quality and care management committee meetings for each contract. Community Care additionally monitors the expectation of 7-day follow-up from inpatient mental health through Provider Performance Issues (outlined above).
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their White counterparts, due to negative perceptions of	**Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders:** In 2020 Community Care, along with primary contractors and OMHSAS, initiated a company-wide Performance Improvement Plan. The Aim of this Performance Improvement Plan is to significantly slow and eventually stop the growth of substance use disorders prevalence among HealthChoices members while improving outcomes for those individuals with substance use disorders. Five related measures have been identified including: 1) Follow-up after high-intensity care for substance use disorder; 2) Substance use-related avoidable readmissions; 3) Mental health-related avoidable	2020	

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
treatment and reluctance to acknowledge symptoms ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience health inequity in behavioral health treatment ***Providers (2.2)*** Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services	readmissions; 4) Psychosocial interventions and pharmacotherapy for opioid use disorders; and 5) Psychosocial interventions and pharmacotherapy for alcohol use disorders. In order to positively impact these measures, Community Care will be implementing the Cascade of Care Model framework, which is implemented in stages, beginning with Stage 1 or Intercept. Stage 2 or Engagement as well as Stages 3 & 4: Retention will then be implemented. In November 2020, baseline data for all five measures was established.		
	Community Care established targeted interventions for the Cascade of Care Intercept Stage 1 as follows: •**Warm Hand Off:** is the linking of a member with an appropriate treatment provider following a substance use disorder related event. The Warm Hand Off intervention focuses on increasing the percent of members when presenting at Physical Health hospitalization or emergency departments who initiate substance use treatment including medication assisted treatment for alcohol use disorder and medication assisted treatment for opioid use disorder over 36 months, by bridging the gap between physical health and substance use disorder treatment systems. Warm Hand Offs are done by peers, case managers of Single County Authorities, Centers of Excellence, or other contracted providers. •**Telehealth Bridge Clinic:** aims to increase the rate of billed telehealth claims for prescribing medication assisted treatment for members with opioid use disorder and alcohol use disorder during or immediately following an inpatient physical health hospitalization or emergency department visit through untapped prescribing services via telehealth designed to engage individuals into substance use disorder treatment. This intervention has a 36 month focus. •**Federally Qualified Health Center Learning Collaborative:** Please see the Collaborative Care at Federally Qualitied Healthcare Centers intervention above. These interventions are designed to impact the five performance measures as well as the overarching Performance Improvement Plan Aims statement and objectives. OMHSAS, as part of this Performance Improvement Plan	Project implementation, including interventions started at the beginning of 2021 and will continue through 2023, with the last update to the project to be reported in September 2024	Updated reports to the Performance Improvement Plan are submitted to County Oversights and OMHSAS/IPRO on a quarterly basis along with an annual submission. In addition to the five performance measures, Community Care annually monitors three indicators to assess the success of the interventions: utilization of medication assisted treatment, overall substance use disorder penetration rate, and PA Death by Drug Overdose Rate.

	required two non-clinical, population health activities, which is new for this process: The **Anti-Stigma Campaign**, known as Community Care's Anti-Stigma Resources and Education Campaign (CCARE) was implemented July 1, 2021. The campaign is designed to reduce stigma for seeking help for substance use disorders resulting in more members engaging in substance use disorder care. The campaign includes anti-stigma education, targeted media posts, webinars, and community outreach and is designed to add to existing statewide substance use disorder anti-stigma efforts rather than duplicate existing programs such as the Life Unites Us and Shatterproof campaigns. The campaign has a focus on Black/African American racial disparities and builds upon recent substance use disorder education and collaboration efforts with community partners and others to expand educational anti-stigma programs. Community Care's Anti-Stigma Resources and Education Campaign resources are posted to the Community Care website along with a brief survey of stigma. This campaign includes Barber/Beauty Shop Project which educates Black/African American barbers and stylists in Pittsburgh area on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. The **Community Health Worker Outreach** intervention (implemented July 1, 2021) focuses on increasing follow up and decreasing readmission through outreach by a Community Health during or immediately following a withdrawal management or inpatient substance use treatment stay to educate members (at least 13 years of age) on care options, facilitate referral and connection to behavioral health services or other community supports. Embedded within this intervention is a mandatory cultural awareness training for all Community Health Workers. Staff training in cultural awareness will improve the work that we do and how we interact with all our members. Sensitivity to different cultures will increase our understanding of help seeking behavior, access issues, and resources available to members.		
	Community Care feels that the ability to access ambulatory		

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
	substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in medication assisted treatment following an inpatient admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Benchmarking:** Community Care distributes annual Provider Benchmarking reports. Reports, which include data related to follow-up after inpatient hospitalization, are sent to providers. Provider network averages are also given for comparison purposes. Providers whose members have not received timely follow-up care are educated about Community Care's expectation of timely follow-up care and its importance to the member's mental health care.	Ongoing activity	The activities of each year are developed by a workgroup that meets every other week. Feedback and updated rates are used to determine the most appropriate action to facilitate change. This activity is reported annually at the Quality and Care Management Committee meetings for each contract and at the Board Quality Improvement Committee. The Provider Benchmarking Publication is annual.
	Starting in 2022, Community Care will be aligning Provider Benchmarking Publications with Value-Based Purchasing arrangements to publish the previous year's results. See IPMH & Ambulatory Provider Value-Based Payment Arrangement intervention listed above. This is to ensure consistency in rate reporting to providers and to meet Appendix U requirements.	The 2022 publication is tentatively set for September 1, 2022.	Activity monitoring is captured in the Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement intervention listed above.
	In 2022, Community Care will establish a new approach of intervention to assist providers who are consistently not meeting goal.	2022	
	Community Care feels that this activity assists in addressing barriers to aftercare experienced by members and providers by defining expectations, providing education, and asking providers to think creatively about overcoming obstacles.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Regional meetings with Physical Health Managed Care Organizations:** Community Care participates in quarterly regional collaboration meetings across the state to collaborate with the physical health managed care organizations Special Needs Units to identify those individuals with complicated health needs and to coordinate all services.	Ongoing practice	Monitoring occurs within the meetings, as needed and as identified in the discussion.

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
People (1.1) Specific to Black/African American members Research shows 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 ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience health inequity in behavioral health treatment	**Social & Racial Justice Steering Committee activities:** The Social & Racial Justice Steering Committee was developed in 2021 to develop interventions to address inequities in five categories - Provider Professional Development, Internal Professional Development, Member Level Advocacy, Human Resource Interventions, Community, and Policy. Workgroups were formed, including staff company-wide to address activities in the five categories. These workgroups identify sources for education and training to be shared internally and with stakeholders around inclusion and cultural diversity.	2021 and ongoing	Internal reports and monitoring occur on a weekly basis as standing agenda items on reoccurring meetings with Senior Management.
	Activities for 2021 in these five areas included: • Providers were surveyed to identify detailed information in order to refer members to requested provider type. • National Alliance on Mental Illness released a list of Black/African American Providers in Allegheny County; Community Care made outreach to providers not already contracted inquiring interest in joining the network. • As part of the Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders Initiative's Anti-Stigma Campaign, the Committee began development of a Barbershop/Beauty Shop initiative that will focus on training Black/African American stylists and barbers and stylists in Pittsburgh area on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. • All Community Care employees were required to take Culturally Competent Skills and Behaviors training. • An internal Social and Racial Justice book club was started for all staff to learn about social and racial issues and meet to discuss and learn from other's perspectives.	2021	Community Care tracks interventions completed by this group and how to best measure effectiveness based on each intervention. We anticipate that the planned interventions (stakeholder education, training on inclusion & cultural diversity and human resource interventions) will have an impact on the gap in disparities seen among our Black/African American population with inpatient episodes and increase the number of providers in the Community Care network who will seek specialization in minority populations.
	Planned activities for 2022 include: • Development of a Social and Racial Justice Advisory Board.	2022	

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
	• Provider trainings on topics of social and racial justice, diversity, and inclusion. • Analyzing Community Care staff demographics to determine disparities and identify strategies to address. • Internal staff trainings related to social and racial justice, diversity, and inclusion. And to start this off, all Community Care Customer Service, Care Management, and Quality staff were required to take "A Culture of Inclusion and Belonging" training in early 2022.		
	Community Care believes that this intervention will improve aftercare by identifying issues across the system and developing companywide interventions to impact inequities.		
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment ***Provisions (3.1) Specific to Black/African American members*** There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care	**Targeted Accessibility Analysis (formally Identifying gaps in treatment availability for Black/African American members using GEOAccess):** In 2021, Community Care developed a Targeted Accessibility Analysis to identify gaps in same-race or culturally competent treatment availability for our Black/African American members. Using GEOAccess Community Care plots geographical information regarding the drive time or the distance members in rural and urban locations must travel to get to a specific type of provider. We apply member race/ethnicity information from DHS enrollment data to their geographical location. A second layer of geographical information is applied for service locations of providers who have voluntarily identified themselves as Black/African American, and yet a third layer for providers who have voluntarily identified themselves as specializing in cultural competency. This data shows gaps in same-race or culturally competent providers reasonably accessible to our Black/African American enrollees. Once possible gaps in treatment availability have been identified, Community Care can develop specific regional interventions to address need.	2021	This report will be used in conjunction with other interventions addressing culturally competent care and when considering network expansion.
	The Targeted Accessibility Analysis has been applied to Allegheny County, which is Community Care's most diverse contract. The analysis entailed slicing the County into 4 sections and showed that less than half of Black/African American members had access to same-race or culturally competent care within the established standard of 2 providers within a 30	2021	

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
	minute drive time.		
	In 2022, Community Care will complete a Targeted Accessibility Analysis for Community Care contracts with disparities and provide an update to contract leadership regarding accessibility to culturally competent care for minorities.	2022	A workgroup meets quarterly to determine contracts for analysis and next steps.
	Community Care feels that it is essential for members to receive culturally competent care. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	**Telehealth:** Telehealth allows behavioral health practitioners to provide clinical services, such as medication management, assessment, diagnosis, and case management to members through two-way, interactive videoconferencing and telephone calls. Prior to the COVID-19 pandemic, Community Care supported these services on a limited basis, particularly for rural areas where drive time and transportation presented as a barrier. At the initiation of the pandemic in March 2020, OMHSAS loosened the regulations surrounding Telehealth to accommodate members utilizing behavioral health services. Members were able to attend appointments via telephone; they did not have to use video or screen sharing technology. Providers were able to expand the amount of services available to members. Preliminary results of the telehealth expansion include increased show rates, high member satisfaction, convenience for practitioners and members, and access to other settings and providers in real time. Satisfaction surveys were conducted by Consumer/Family Satisfaction Teams of 200 members from rural counties regarding their experiences of receiving services via telehealth. Almost all members who responded agreed or strongly agreed that their provider was able to "meet all of my behavioral health needs."	2020	The availability of telehealth services is regularly monitored as part of network expansion requests and Network Adequacy Workgroup. Community Care has developed reports to monitor the use of telehealth services and regularly reminding providers to use telehealth place of service codes which was released in the March 16, 2020 Provider Alert, titled COVID-19 Update: Telehealth Services. The use of this code will be instrumental in Community Care obtaining accurate data. Provider Alert: https://providers.ccbh.com/uploads/files/Provider-Alerts/20200316-alert4-covid19.pdf
	Community Care analyzed the HEDIS FUH data for inpatient mental health discharges between March 16, 2020 and December 1, 2020. According to this information, almost half of all HEDIS qualified follow-up was delivered via telehealth. Specifically, 48% of 7-day follow-up appointments. These findings are driven by the quarantine status of the COVID-19		Additionally, Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 7-day HEDIS FUH rates. This

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
	mitigation efforts in 2020 but is a positive indicator of future potential.		data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.
	In accordance with OMHSAS directives in March 2020 when the disaster declaration was issued, services were permitted to be delivered via telehealth. The allowance of telehealth will remain in effect during the emergency disaster declaration authorized by Governor Tom Wolf. Four provider alerts have been issued for additional guidance on service delivery expectations and billing as well as Fraud, Waste, and Abuse. Community Care is also working to update telehealth service delivery post-COVID-19, including any OMHSAS/CMS guidance to support the continuation of services via telehealth platforms.		
	In 2021, the Consumer Action Response Team in Allegheny County added two questions to the member Satisfaction Survey related to telehealth with positive results. ▪ 80% of survey respondents (n. 1,374) indicated that telehealth made it easier for them to receive the services, ▪ 72% of survey respondents (n. 349) rated their experience with telehealth as satisfied or very satisfied. This data is promising when evaluating the overall effectiveness and satisfaction of telehealth services.	2021	
	It is anticipated that this service may be retained in the future, although more trainings would need to be offered to providers on topics related to telehealth, developing billing processes, and addressing current documentation procedures (e.g., how to obtain signatures on a treatment plan).		
Provisions (3.2) Medication appointments with psychiatrists are often hard to secure in a timely manner	**Telepsych:** Telepsychiatry allows behavioral health practitioners to provide clinical services to patients at remote, usually rural, locations through two-way, interactive videoconferencing, sparing both practitioners and patients the time and expense of long-distance travel. It allows members to access psychiatrists that would not otherwise be available to them. Patients may connect to a specialist via the telehealth network from their community healthcare facility.	2005 - ongoing	Community Care will continue to take an active role in expanding telepsychiatry and monitor its utilization via the number of members served and providers involved. Telepsychiatry services and related data is reported annually at Community Care's Board Quality Improvement Committee.
	Through December 2020, close to 31,054 unique members have been served via telepsychiatry, receiving psychiatric evaluations and medication management appointments.	2020	

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	Approximately 73 providers currently utilize telepsychiatry services to better meet the needs of our members.		
	Community Care feels that telepsych services permits a number of members to receive psychiatry services that wouldn't ordinarily be accessible, or much sooner than would be permitted in a traditional setting. This intervention positively impacts HEDIS FUH rates by increasing accessibility and reducing barriers.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Utilization Management Provider Notification:** Notification processes are in place to inform Blended Case Managers, Family Based Mental Health Services, or other service providers as applicable, at the time of authorization of an inpatient admission for any of their members and to coordinate aftercare for children discharged to shelter placements.	Ongoing practice with process updated in 2020 Intervention occurs as part of the Care Management daily activities	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision.
	Community Care currently does not have a reliable method of collected the Provider Notification data on an aggregate level. At this time Community Care will continue to explore ways to aggregate this data.		
	Community Care believes this activity impacts aftercare rates by involving other service providers in supporting members during and after inpatient mental health stays.		

CCBH: Community Care Behavioral Health.

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

<table>
<tr><th colspan="2">RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)</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 and quality improvement plan, was identified using the MY 2020 FUH Goal Report.
Attachments:
MY 2020 FUH Goal Report_01172022_updated

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.
Attachments:
MY 2020 FUH IPRO Dashboard Disparities

The following information/analysis was used to identify the factors that contributed to underperformance:
• 2021 HealthChoices Membership Analysis
• 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</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 root-cause-analysis and quality improvement plan:
<table><tr><th>Performance Measure</th><th>MY 2020 (N)</th><th>MY 2020 (D)</th><th>MY 2020 Rate</th></tr><tr><td>FUH HEDIS 30-Day All Ages</td><td>9,745</td><td>14,838</td><td>65.68%</td></tr></table>
The following disparities with a statistically significant difference 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 compared to the White cohort.
o This also applied to the Allegheny contract (HCAL), Berks contract (HCBK), Erie contract (HCER), Lycoming/Clinton contract (HCLC), 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 346 members with an inpatient mental health admission in HCBK, who fall under "other/chose not to respond" for race, 64% identified as Hispanic.
o For the remaining 36% of members who fall under the "other/chose not to respond" for race, additional discerning demographics were unable to be identified.
o Interventions developed to address all Community Care members will apply in this situation.
• The HCER non-Hispanic cohort with an inpatient mental health admission were less likely to have follow-up within 30-days.
Community Care conducted a literature review and data analysis of Hispanic and non-Hispanic members with an inpatient mental health admission in 2020. Results are as follows:
• Among Community Care's HealthChoices enrollees, 89.1% identified as non-Hispanic (2021 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:
<table><tr><th>HCER</th><th>HCYY</th></tr><tr><td>93.8%</td><td>84.4%</td></tr></table>• Literature reviews indicate that Hispanic individuals typically have lower rates of treatment engagement than non-Hispanic individuals. Community Care's Membership Analysis supports this hypothesis with only 14% of Hispanic enrollees engaging in services in 2020, compared to 22% of non-Hispanic members. However, further data analysis of HEDIS discharges between 2018 to 2020 indicate that Hispanic members in</td>
</tr>
</table>

individuals.

- A drilldown analysis of members with and without 30-day follow-up appointments in aggregate and contract specific groupings.
- Barrier analysis of the North Central State Option completed by the Behavioral Health Alliance of Rural Pennsylvania.
- Board Quality Improvement Committee reports for accessibility of routine appointments, network availability, and assessment of cultural needs.
- Compilation of the Discharge Management Planning follow-up meetings that occurred with inpatient mental health providers in 2019.
- Information from Community Care's RCA submitted in 2020, 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.
- Review of current literature.

Attachments:
2018-19 Inpatient Barriers and Interventions
2021 HealthChoices Membership Analysis
2022 HCAL African American Target Analysis

treatment are more likely to follow-up and remain engaged in treatment.

- Interventions developed to address all Community Care members will apply in this scenario due to the majority of our members falling in the non-Hispanic category.

Performance Measure: FUH HEDIS 30-Day All Ages				
Rates with SSD				
Contract	**Cohort 1**	**Rate 1**	**Cohort 2**	**Rate 2**
HC	White	66.4%	Black/African American	61.7%
AL	White	66.2%	Black/African American	62.1%
BK	White	60.6%	Other/Chose not to respond	68.7%
ER	Non-Hispanic White	59.7%	Hispanic, all Races	79.5%
ER	White	60.2%	Black/African American	49.1%
NS	White	67.7%	Other/Chose not to respond	57.3%
YY	White	69.0%	Black/African American	60.7%

<table>
<tr><th colspan="2">RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)</th></tr>
<tr><td>Accessibility to Routine OPT and FU Report
Assessment of Cultural needs
BHARP County Input on Barriers from 2-14-22
BHARP Presentation Legislation Hearing 5 11 15
Network Availability Report
References</td><td></td></tr>
<tr><td>List out below the factors you identified in your RCA. <u>Insert more rows as needed</u> (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).</td><td>Discuss each factor's role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").</td></tr>
<tr><td>People (1.1) Specific to Black/African American members
Research shows 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, 15.7% identified as African American (2021 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows:
<table>
<tr><th>HCAL</th><th>HCBK</th><th>HCER</th><th>HCLC</th><th>HCYY</th></tr>
<tr><td>37.6%</td><td>8.7%</td><td>19.8%</td><td>12.6%</td><td>13.5%</td></tr>
</table>
In 2020, 61.7% of the Black/African American members with an inpatient mental health admission had follow-up within 30-days. This is significantly less than White members in 2020, who had a 30-day follow-up rate of 66.4%. Community Care's data analysis indicates that the inpatient length of stay of Black/African American members have an impact on the likelihood of aftercare. The inpatient mental health average length of stay for Black/African American members who had follow-up was 13.8 for 30-days, while the average length of stay for those who did not have follow-up was 8.8 days. In contrast, the average length of stay for White members was 11.6 days, regardless of whether they had aftercare or not. 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. 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 (Centers for Disease Control, 2022). For 2016-2020, suicide was the second leading cause of death in Black children aged 10-14, and third</td></tr>
</table>

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)	
	for Black individuals aged 15-34 in Pennsylvania. This factor is deemed critical.
	Current and expected actionability: Community Care has implemented interventions to specifically address disparities affecting our Black/African American population. The variance in follow-up between our White and Black/African American cohorts was 9 percentage points in 2019 to 5 percentage points in 2020. Further data is needed to determine if the improvement is artificial due to extraneous factors, more specifically the COVID-19 pandemic. This factor is expected to be actionable.
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	***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 information about barriers from inpatient mental health facilities through provider discussions and quality improvement plans. Specifically in 2019, Community Care conducted interviews with 8 inpatient mental health 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. Providers reported 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. In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Transportation was identified as a barrier effecting members in rural communities. 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. • In 2020, Care Managers conducted Admission Interviews with 2,793 distinct adult members who were readmitted to an inpatient mental health or residential substance use treatment facility within 30 days. During interviews at the second admissions, members were asked if they were scheduled a follow-up appointment after the first admission, if they kept their follow-up appointment from the first admission, and if not, why. Fifty-nine percent of these members reported not keeping the follow-up appointment from the first admission. When asked why, 60% indicated they had a relapse in symptoms or readmission prior to the follow-up. The remaining 40% indicated the choice not to attend, forgot about the appointment, or needs related to transportation, legal status, housing, finances, or childcare. • In 2020, Community Care's Care Managers also spoke with 672 members who did not attend aftercare to determine barriers. The most common responses for not attending were choice, vocational schedule, legal status, illness, transportation, technology, and housing. 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

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)	
	sufficient planning, which is difficult to do from the inpatient setting. 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 (1.3) 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 inpatient mental health as part of the Admissions Interview activities which is described further in the interventions section. Specifically in 2020, Admission Interviews indicated that for readmitted adult members who did not attend aftercare appointments 33% did not have aftercare scheduled at discharge, while 11% reported difficulty with their medications as the reason for readmission, and 8% of adults indicated it was lack of timely follow-up from the first admission. Although members with readmissions are excluded from data for HEDIS follow-up, Community Care has access to barriers members are experiencing after an inpatient mental health 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. In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Unclear discharge instructions from inpatient mental health facilities is a barrier identified for members attending aftercare. 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 (1.4) 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 inpatient mental health 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. During barrier discussions, providers reported that members often decline aftercare. In 2020, Care Managers conducted Admission Interviews with 2,793 distinct adult members who were readmitted to an inpatient mental health or residential substance use treatment facility within 30 days. Of the members who had an aftercare appointment scheduled but did not attend, 17% indicated because they chose not to. Furthermore, the Aftercare Outreach Care Managers spoke with 672 members in 2020 who did not attend their scheduled aftercare appointment and 14.4% indicated they declined to attend. In 2022, the Behavioral Health Alliance of Rural Pennsylvania conducted a barrier analysis with the 24 counties encompassing the North Central State Option by meeting with County Administrators and compiling themes. Member noncompliance is a barrier identified as impacting FUH.

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)	
	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 inpatient mental health admissions. Due to these perceptions, individuals may decline aftercare when offered by inpatient 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. 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 (1.5) 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 Care Management activities. According to an analysis of Integrated Care Plan activities (described further in the interventions section), 45% of the HEDIS qualified discharges in 2020 had an Integrated Care Plan, indicating a physical health need. Community Care also analyzed data captured through Admissions Interviews in 2021. There were 3,551 adult and 376 child interviews completed for members at inpatient facilities and 31.1% of adults and 10.1% of child members reported the inpatient mental health facility was actively helping them coordinate care for a medical condition. 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.
	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.
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment	***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, 15.7% identified as African American (2021 HealthChoices Membership Analysis). When analyzed across contracts, this distribution was not consistent. For the contracts with a statistically significant disparity, the distribution of members identifying as Black/African American is as follows:

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)	
	<table><tr><th>HCAL</th><th>HCBK</th><th>HCER</th><th>HCLC</th><th>HCYY</th></tr><tr><td>37.6%</td><td>8.7%</td><td>19.8%</td><td>12.6%</td><td>13.5%</td></tr></table> In 2020, of the 2,319 Black/African American members that had an IPMH admission, 61.7% had an appointment within 30-days. This is statistically significantly less than White members in 2020, who had a 30-day rate of 66.4%. 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 2021 Membership Analysis, Schizophrenia is the seventh most prevalent diagnosis among our Black/African American members in treatment, accounting for 6% of those members. This is compared to the White members in treatment, for whom Schizoaffective Disorder ranks tenth, accounting for 3% of those members. These are the only psychotic disorders among the ten most prevent for each cohort. • An analysis of the 2020 member level drilldown report, 34.2% of Black/African American members with an inpatient mental health admission were being treated for a primary diagnosis of a psychotic disorder (Schizophrenia, Schizoaffective Disorder, or Other Psychotic Disorder). In contrast, only 21.1% of White members were being treating for a psychotic disorder. • The 2020 drilldown also reveals that a total 1.33% (n.31) of Black/African American members had an inpatient stay of more than 100 days compared to .78% (n.88) of White members. • Of the 31 Black/African American members with an inpatient stay over 100 days, 26 (84%) were being treated for a psychotic disorder. For the White members 62 (70%) were being treated for a psychotic disorder. While conclusions cannot be made with these low numbers, there is a need to conduct more research. 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) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services	***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 2021 HealthChoices Membership Analysis, 11% of Community Care's members in treatment have an opioid use disorder and an additional 4% have an alcohol related disorder, placing them both in the ten most prevalent diagnoses for members in treatment. Of the 30-day follow-up appointments in our 2020 HEDIS sample, 2% were for Buprenorphine Services or Methadone Maintenance. Since this was the first appointment after inpatient mental health, we can assume this is not a new service for these members and there is likely another sample initiating medication assisted treatment services. Individuals with an opioid use disorder are at the highest risk for an overdose death but only 20% access treatment (DHS, 2021).

<table>
<tr><th colspan="2">RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)</th></tr>
<tr><td></td><td>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 opioid use disorder that includes medication assisted treatment is a contributing factor to delays in receiving treatment. Community Care feels that the ability to access medication assisted treatment and substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in medication assisted treatment or other substance use disorder treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen.
Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). There were 3,551 adult interviews completed for members at inpatient mental health facilities in 2021; of those, 1,106 were interviews for members who had a previous inpatient admission in the past 30 days. When asked the reason for the readmission, 23.9% of adult members reported it was for substance use. For adult member interviews that were not a readmission (n. 4,172), 20.4% reported the reason for the inpatient mental health admission was substance use. This factor is critical.</td></tr>
<tr><td></td><td>Current and expected actionability:
Community Care has developed several interventions to assist members to access medication assisted treatment and substance-use treatment needs. We anticipate that we will continually make this a focus of company-wide activities.</td></tr>
<tr><td>Provisions (3.1) Specific to Black/African American members
There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care</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 has goals set for ratios of members per provider meeting availability standards:
<table>
<tr><th>Physician</th><th>Psychologist</th><th>Non-Doctoral Level Therapist</th><th>Ambulatory Provider Organization</th></tr>
<tr><td>5,000:1</td><td>2,000:1</td><td>2,000:1</td><td>750:1</td></tr>
</table>
This data is calculated by distance to providers by members' home address. Our annual Network Availability report indicates that in August of 2021, Community Care was not currently meeting goal for Physician or Psychologist. Community Care collects information from providers during credentialing and re-credentialing regarding voluntary disclosure of race (for private practitioners) and specialization working with minority populations (practitioners and facilities). Although not a direct comparison, we have data indicating the following:
<table>
<tr><th>Total Black/African American enrollees on 02/08/2022:</th><td>196,506</td></tr>
</table>
Total practitioners who voluntarily identified as Black/African American by category:
<table>
<tr><th>Psychiatrist</th><th>Psychologist</th><th>Masters Level</th></tr>
<tr><td>3</td><td>5</td><td>36</td></tr>
</table></td></tr>
</table>

Ratio of practitioners who voluntarily identified as Black/African American by category per number of same-race enrollees:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1
65,502:1	39,301:1	5,459:1

Members: per provider

Ratio of practitioners and facilities who voluntarily identified as specializing in minority populations, specifically Black/African American minorities by category per number of same-race enrollees:

Psychiatrist Goal 5,000:1	Psychologist Goal 2,000:1	Masters Level Goal 2,000:1	Facilities (MH OP Clinics, SUD OP Clinics, & FQHC/RHC) Goal 750:1
21,834:1	6,141:1	3,573:1	5,311:1

Members: per provider

As part of our 2021 RCA/QIP, Community Care developed a report to identify gaps in treatment availability for Black/African American members using GEOAccess to plot geographical locations of provider service address and member's home address (described further in the interventions section). Allegheny County has the most Black/African American members by both proportion and whole number, compared to other contracts. Actually, Allegheny County has more Black/African American members than all other Community Care contracts combined. For this reason, the Targeted Accessibility Analysis report was applied to Allegheny County by breaking it into 4 quadrants to identify areas of Black/African American member density and available providers who are same-race or identify as specializing in Black/African American treatment.

Quadrant	Percent of Black/African American members under 18 meeting the access standard to culturally competent care	Percent of Black/African American members 18 & over meeting the access standard to culturally competent care
NE	38.2%	36.5%
NW	39.6%	42.6%
SE	40.0%	38.7%
SW	40.0%	40.1%
Urban Access Standard: 2 providers in 30 minute drive time		

Analyses have not been completed for the other contracts with a statistically significant disparity (HCBK, HCER, HCLC,

or HCYY) between the White and Black/African American members due to the low volume of Black/African American members and providers who have voluntarily identified.

		HCBK	HCER	HCLC	HCYY
02/08/2022 Total Black/African American Members Proportion of Enrollees		9,719 8.7%	16,199 19.5 %	5,080 12.9%	16,279 13.6%
Black/African American same-race providers	Psychiatrist	0	0	0	0
	Psychologist	0	0	0	0
	Master's Level	0	2	0	1
Specializing in minority populations: Black/African American	Psychiatrist	1	1	0	1
	Psychologist	2	2	1	2
	Master's Level	3	3	1	3
	Facilities	3	4	1	3

Based on this information, Community Care can reasonably deduce that the number of providers who are Black/African American or who specialize in this minority population do not meet the needs of our Black/African American members.

This is important because Black/African American individuals are more likely to trust and engage with Black or African American providers but less likely to find one (Evans, Rosenbaum, Malina, Morrissey, and Rubin, 2020). Historically Black individuals do not have adequate access to same-race treatment providers. In the United States, only 2% of psychiatrists identify as Black (Starks, 2021) and 4% of psychologists (Healthline, 2021). This is crucial because Black and African American providers are known to provide more appropriate and effective care to Black and African American individuals (Mental Health America, 2021).

As this barrier will take time to address, The National Alliance on Mental Illness recommends that until the gap is closed it should be filled with culturally competent care. In order for a provider to be culturally competent, it goes beyond having a diverse workforce. Providers need to invest in gaining cultural knowledge of the populations they serve as it relates to help-seeking, treatment, and recovery (SAMHSA, 2014). Community Care's ability to gathering information on culturally competent providers is limited by the changing workforce. Staff turnover plays a significant role on the ability to maintain competency.

This factor is deemed critical.

<table>
<tr><th colspan="2">RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)</th></tr>
<tr><td></td><td>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 availability will continue to affect Community Care's ability to adequately address the actual root cause.</td></tr>
<tr><td>Provisions (3.2)
Medication appointments with psychiatrists are often hard to secure in a timely manner</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Availability of psychiatrists has been an ongoing barrier to services in the State of Pennsylvania. Although Community Care consistently meets accessibility standards for Psychiatry, providers report difficulty getting individuals appointments with existing psychiatry time. In 2015 the Behavioral Health Alliance of Rural Pennsylvania did a point in time survey of psychiatric providers that indicated a need of double the psychiatric time currently available. This included the capacity of telehealth services and physician extenders at that time. Of the 14 surveyed providers, they are providing a 617 hours of psychiatric clinic time. Their study indicated a need for almost double the amount of current time being provided. While other services are available, psychiatry is essential for individuals with significant mental illness or serious emotional disturbances. Psychiatrists are often splitting their time between outpatient and other services, such as inpatient mental health, partial hospitalization, dual diagnosis treatment teams, etc.
A need for more psychiatric time seems to be a theme across the State. Community Care's annual Network Availability report indicates that in August of 2021, Community Care was not currently meeting goal for the enrollee to physician ratio of 5,000:1 with an actual ratio of 6,337:1. If we look at this analysis over time, we can see that although HealthChoices membership has grown, the number of Psychiatrist site's delivering the service has decreased.
<table>
<tr><th colspan="8">Community Care contracted Psychiatrist by site count and ratio</th></tr>
<tr><td colspan="2">August 2018</td><td colspan="2">August 2019</td><td colspan="2">August 2020</td><td colspan="2">August 2021</td></tr>
<tr><td>Site Count</td><td>Ratio</td><td>Site Count</td><td>Ratio</td><td>Site Count</td><td>Ratio</td><td>Site Count</td><td>Ratio</td></tr>
<tr><td>216</td><td>4,538:1</td><td>208</td><td>4,783:1</td><td>205</td><td>5,515:1</td><td>191</td><td>6,337:1</td></tr>
</table>
In 2019, Community Care conducted interviews with 8 inpatient mental health 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. Specific barriers identified by these provides included "Psychiatry is hard to get" and Medication appointments are particularly challenging".
Community Care conducts interviews with members who have a readmission to inpatient mental health as part of the Admissions Interview activities (described further in the interventions section). There were 3,551 adult and 376 child interviews completed for members at inpatient mental health facilities in 2021; of those, 1,216 were interviews</td></tr>
</table>

<table>
<tr><th colspan="4">RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)</th></tr>
<tr><td colspan="2"></td><td colspan="2">for members who had a previous inpatient admission in the past 30 days. When asked the reason for the readmission, 17.1% of adults and 9.1% of children reported difficulty with their medications.
This factor is deemed important.</td></tr>
<tr><td colspan="2"></td><td colspan="2">Current and expected actionability:
Community Care has developed some interventions to work with current capacity but has a limited scope to address this barrier specifically.</td></tr>
<tr><th colspan="4">Quality Improvement Plan for CY 2022</th></tr>
<tr><td colspan="4">Rate Goal for 2022 (State the 2022 rate goal from your MY2020 FUH Goal Report here):</td></tr>
<tr><td colspan="4">The factors above can be thought of as barriers to improvement. <u>For each barrier</u> identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2021 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.</td></tr>
<tr><td><u>Barrier</u></td><td><u>Action</u> Include those planned as well as already implemented.</td><td><u>Implementation Date</u>
Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)</td><td><u>Monitoring Plan</u>
How will you know if this action is taking place? How will you know the action is having its intended effect?
What will you measure and how often? Include what measurements will be used, as applicable.</td></tr>
<tr><td>People (1.2)
Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues

People (1.3)
Inadequate discharge plans and/or issues with prescribed</td><td>Admissions Interview: The Utilization Management Children’s and Adult High Risk Care Managers conduct longitudinal care management and outreach to high-risk members who encounter difficulties maintaining stabilization and community tenure. The Care Managers meet with these members at inpatient mental health facilities and substance use disorder treatment settings to provide face-to-face intervention, complete the interview tool to assess strengths/needs, and collaborate with the treatment team and inpatient staff to address aftercare planning, coordination, and reduce recidivism.

In 2020, the readmission interview tool was expanded to include members with initial admissions and readmissions that do not meet the original eligibility criterion of readmission within 30 days. This expansion granted the opportunity for the intervention to serve as prevention. In addition, the high-risk care management intervention has been expanded to include children</td><td>Ongoing practice with process updated in 2020

Intervention occurs as part of the Care Management daily activities</td><td>Member needs reported in the Admissions Interviews, including those around physical health and medications, are regularly monitored through a Tableau Dashboard. Doing so allows Community Care to identify trends related to member needs and respond appropriately.</td></tr>
</table>

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	as well as individuals readmitted to substance use disorder treatment facilities. Also in 2020, many Admissions Interviews were completed virtually with members due to COVID-19 mitigation efforts.		
	In 2020 there were a total 2,934 adult and 58 child interviews were specific to inpatient mental health admissions. For members that had a completed Admissions Interview, 68.6% had 30-day HEDIS follow-up. This data suggests that members who received a complete Admissions Interview were significantly more likely to attend an aftercare appointment, specifically for the 7-day measure. To further support this finding, the 2019 7-day HEDIS follow-up rate for members who completed the Admission Interviews was 8 percentage points above our validated HEDIS rate. Improvement in the 7-day rate will inherently impact the 30-day rate.	2020	Community Care developed a monitoring report that was completed in late 2021 to pull information from the Admissions Interview template in the electronic record and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.
	Community Care Care Management Department monitors barriers to aftercare reported by members through this process on an ongoing basis through a Tableau Dashboard. In 2022, Community Care plans to add a racial and ethnic filter to the dashboard for contracts with disparities to routinely monitor and address barriers specifically identified by minority populations.	2022	
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers, providing education to members and providers, coordinating care, and assistance in aftercare planning.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	**Aftercare Outreach:** This intervention has evolved over time to best fit members' need. Community Care provides outreach to members who may be at risk. All members being discharged from acute levels of care and who are not transitioned to another non-ambulatory service or placement receive follow-up to encourage adherence to a community-based aftercare appointment. The Care Manager will assist with problem solving and engaging the member to his/her aftercare appointment. If there is an Intensive Care Manager, Resource Coordinator, or Service Coordinator assigned, the Care Manager can contact the provider to ensure appropriate linkages for follow-up care.	Ongoing practice Intervention occurs as part of the Care Management daily activities	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	In 2020, Community Care made Aftercare Outreach calls to 53% of our HEDIS Qualified Discharges and 13.4% were successful. An analysis of the data indicates that members who had a successful Aftercare Outreach call were 10-14% more likely to have timely follow-up. Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.	2020	Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Allegheny Care Management Team:** (HCAL) The Integrated Care Team assists Allegheny County Health Choices members, families, health plans, and providers in facilitating coordination of physical health/behavioral health care. The team advocates for members with the four physical health managed care organizations serving Allegheny County and provides behavioral health history, referrals, and direct provider and member outreach. The physical health managed care organizations receive daily internal referrals from care managers on Community Care child and adult teams for members with physical health needs and obtain member consents for enhanced coordination of care. The team provides training regarding physical health/behavioral health integration to behavioral health providers and member/community groups and supports multiple UPMC care coordination initiatives. Their established relationships with health plans and providers promote a 'whole health' collaborative approach. Community Care believes that this intervention improves	Ongoing practice Intervention occurs as part of the Care Management daily activities	Monitoring for the needs identified occurs on an ad hoc basis through Clinical Supervision.

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	aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services	**Centers of Excellence:** The Pennsylvania Department of Human Services launched the Centers of Excellence in 2016 to expand access to medication assisted treatment and other effective treatments. Centers of Excellence are licensed substance use disorder treatment providers that provide counseling, methadone, buprenorphine, or naltrexone assisted treatment. Centers of Excellence offer members diagnosed with an opioid use disorder peer support throughout all stages of recovery as well as Care Management to assist members in identifying, receiving, and sustaining treatment. Community Care's Care Management team helps individuals with opioid use disorder navigate the health care system by facilitating initiation into opioid use disorder treatment from emergency departments and primary care physicians; helping individuals transition from inpatient levels of care to ongoing engagement in community-based treatment; and facilitating transition of individuals with opioid use disorder leaving state and county corrections systems to ongoing treatment within the community.	Centers of Excellence initiated in January 2017 and enrollment began July 2019. Activities around this initiative remain ongoing.	Regular data reviews now occur by Community Care to ensure that Centers of Excellence thrive over time and feedback webinars continue to occur monthly with providers, though the live format has been suspended during the COVID-19 crisis; the feedback now includes slides that are updated monthly and emailed to all agencies and county stakeholders. Additionally, Community Care created a range of telehealth documents for medication assisted treatment providers, including the Centers of Excellence, which are posted on Community Care's website (https://providers.ccbh.com/COVID-19-info/providing-treatment).
	Community Care reviews data metrics related to Centers of Excellence on a quarterly basis. Information reviewed includes length of stay, type of medicated assisted treatment, diagnosis, category of enrollment, and gender. Additionally, in February 2021, Community Care added race and ethnicity data to the to the monitoring. In 2021, the Department of Human Services expanded this program beyond the original 45 agencies to increase access and capacity. By September 21, 2021 there were 240 Centers of Excellence locations reflecting at least 61 unique organizations in Pennsylvania. Over 40 Centers of Excellence in Community Care's network have actively submitted claims. Enrollment started in July 2019 and as of December 2021, a total of 11,737 Community Care members have enrolled in a Center of Excellence. In the 2021 calendar year alone, 8,866 unique Community Care members received at least one Centers of Excellence claim. There are 5 types of Centers of Excellence in our network; Opioid Treatment Programs, Substance Use Disorder - Outpatient, Residential and	2021	

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	Outpatient Programs, Single County Authorities, and Office Based Opioid Treatment. The vast majority (August 2021, 72%) of Community Care members in Centers of Excellence are enrolled in an Opioid Treatment Program.		
	Community Care will be collaborating with the University of Pittsburgh Program and Evaluation Research Unit and the Department of Human Services to develop a series of standard algorithms for calculating enrollment, engagement, and retention rates for use by Centers of Excellence and managed care organizations.	2022	
	Community Care feels that the ability to access medication assisted treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health facilities. Members being enrolled in medication assisted treatment following an inpatient mental health admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		
Providers (2.2) *Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment service**s***	**Certified Assessment Centers -** (HCAL) The Certified Assessment Centers program was developed in 2019 and implemented in 2020 in Allegheny County with four providers. Certified Assessment Centers are designed to ensure timely access to substance use services of Allegheny County residents' choice and based on results of their level of care assessment. The purpose of the Certified Assessment Centers is to provide timely (within 48 hours) level of care assessments for substance use disorders, offer referrals and warm handoffs to appropriate substance use services and supports, reduce obstacles to initiating treatment, and ensure treatment is initiated. All clients are offered options of their choice for providers who would deliver the recommended level of care, and direct admissions are expected to occur. The PA Get Help Now Hotline and providers triage referrals to Certified Assessment Centers, who provide level of care assessments and facilitate further linkages to appropriate substance use disorder treatment providers. In 2021, a value-based payment arrangement will be implemented with Certified Assessment Centers to promote timely access to level of care assessments and increase timely linkage to substance use disorder services.	2020 – Present Ongoing	Allegheny County Department of Human Services is partnering with Community Care to align and enhance reporting with identified measures, including level of care admissions within 14 days of level of care assessments completion, completion of a level of care assessments within 48 hours of request from any source, attendance at all required provider meetings, and submission of timely data reports. The value-based payment arrangement for Certified Assessment Centers is anticipated to begin implementation in July 2021.
	Community Care feels that the ability to access substance use		

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	disorder treatment affects our members' recovery and will likely impact the follow-up of our co-occurring members from inpatient mental health.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Collaborative Care at Federally Qualified Healthcare Centers:** (HCAL, HCNE, HCYY, HCBK, HCCH, HCCK) Community Care believes that implementing Collaborative Care to integrate primary care and behavioral health is a clear remedy for many of these problems with co-morbid conditions. Based on principles of effective chronic illness care, Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained Primary Care Physicians, and embedded Behavioral Health Practitioners provide evidence-based psychosocial treatments and/or medication, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. The model consistently results in improved patient and provider satisfaction, improved functioning, and reductions in health care costs, achieving the Triple Aim of health care reform.	Ongoing practice	Federally Qualified Health Centers are a primary focus for the Director of Integration and monitoring activities occur on a regular basis. Community Care hosts quarterly Provider Meetings with Federally Qualified Healthcare Centers, of which data metrics are a routine topic.
	Community Care currently has 27 Federally Qualified Health Center providers at 94 locations throughout the network. In 2021 Community Care partnered with Pennsylvania Association of Community Health Centers to invite all Federally Qualified Health Centers across Pennsylvania to participate in a Learning Community to focus on increasing the utilization of Collaborative Care and engagement in substance use disorder treatment with increasing rates of medicated assisted treatment for alcohol use disorders and opioid use disorders within Federally Qualified Health Centers . A total of 14 different providers participating in some or all of the sessions. As part of the Learning Community, which was active June - November, 2021, Federally Qualified Health Centers were asked to provide substance use disorder screening information. This information found that the number of screenings increased over time, more individuals with alcohol use disorder or opioid use disorder were identified, the number of individuals receiving brief intervention for alcohol use disorder and opioid use disorder increased, and most importantly, the number of individuals treated for alcohol use disorder and opioid use disorder at the Federally Qualified Health Centers increased	2021	

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	over time.		
	Community Care has implemented a joint value-based purchasing arrangement with UPMC for You. Six Federally Qualified Health Centers were offered the opportunity participate in the value-based purchasing arrangement (five in Allegheny County; one in York County). The value-based purchasing arrangement includes physical health and behavioral health metrics. This is the first combined physical Health/behavioral health value-based purchasing activity that Community Care has undertaken. The value-based purchasing arrangement started April 1, 2021 and will run for one year. Goals for this value-based purchasing arrangement are to improve tobacco screening, tobacco cessation, depression screening, and antidepression medication adherence.	April 1, 2021 - March 31, 2022	Monitoring for this intervention is driven by value-based purchasing arrangements. Quarterly Meetings occur to update providers on the metrics.
	Community Care plans to build on the success of the Learning Community by hosting 4 Quarterly Federally Qualified Health Center Collaborative Care meetings in 2022 with a continued focus on expanding the usage of the Collaborative Care model and increasing screening and interventions for individuals with substance use disorders.	2022	During the 2022 Federally Qualified Health Centers Collaborative Care meetings, Community Care will facilitate open discussions around expanding the usage of Collaborative Care and increasing screenings and treatment.
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate discharge plans	**Community Based Care Management:** Community Based Care Management is a new Care Management program aligning with the Department of Human Service's initiatives around whole-person healthcare reform. Elements of this program include: • Enhancing care management activities in the community by working directly with members and providers; • Enhancing physical and behavioral health coordination to address whole person health and wellness; • Decreasing unplanned, emergent admissions; • Increasing access to healthcare; • Enhancing crisis and substance use disorder services; • Screening members for Post-Partum Depression; and, • Screening of social determinants of health and linking members to services and resources. **Community Health Workers** are an integral part of this program	2020 - Planning phase	Community Care has a Data Analytic staff specific to this program. In 2022, this staff will assist with providing data of members supported by Community Based Organizations, Care Manager and Community Health Worker interventions, and outcomes related to use of emergent and community-based services.

and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending ***People (1.5)*** Some members have competing physical health needs which makes setting up aftercare difficult	and are responsible for completing face to face or telephonic admission and readmission interviews with members to identify barriers to services and resources and to plan for aftercare, advocating for person centered treatment and aftercare planning, participating in interagency and collaboration meetings with providers and members, providing ongoing follow up and support by meeting with the member in the community at provider sites and in the member home, completing warm hand offs to community resources and providers, following up with members who identify social determinant of health challenges during Customer Service New Member Welcome Calls and Post Discharge Outreach Calls, supporting the Community Based Organizations with identifying Community Care members, ensuring coordination with current Behavioral Health Providers, and assisting to link members to Behavioral Health services. Community Based Care Management also includes the use of **Pre/Post Natal Care Managers** who outreach to, engage, assess, and link members during pregnancy and post-delivery or end of pregnancy, who have an identified behavioral health need. The Pre/Post Natal Care Manager coordinates with the physical health managed care organizations to link the members to prenatal care and resources, as well as to transfer members to the physical health managed care organizations' maternity programs if there are no identified behavioral health needs. Community Based Care Management allowed Community Care the opportunity to partner with and provide funding for staff and administrative costs to **Community Based Organizations**. The Community Based Organizations provide services and resources which address social determinants of health the greatly impact the HealthChoices members.		
	In 2021, Community Care hired additional internal positions to expand and enhance the community work that is done to support members. Blair, Bedford/Somerset, and Lycoming/Clinton contracts opted to utilize existing positions either within Community Care, county partners, or the HealthChoices teams to absorb some of the Community Based Care Management responsibilities. New positions included Community Health Workers and Pre/Post Natal Care Managers per specific contracts, and a Data Analytics position shared amongst all contracts.	2021- Development phase	

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	Community Care contracted with 24 Community Based Organizations in 2021 and 1 contracted directly with Blair HealthChoices. Community Based Organizations were chosen by determining the greatest social determinate of health that impacted the community and then contracting with an agency that addressed those barriers. Examples of Community Based Organizations ranged from emergency shelters and transitional housing to local United Way and Community Action organizations.		
	In 2021, Community Health Workers engaged with 657 unique members and completed a total of 4,188 in person or phone contacts or attempts with members, Pre/Post Natal Care Managers engaged with 1,065 members, and Community Based Organizations have supported 3,420 members.	2021-2022 – Implementation phase	Community Care is engaging the Research and Outcomes Team to help build a foundation for future outcomes reporting.
	Community Care will continue to explore increasing and identifying new opportunities for community engagement with members, providers, and Community Based Organizations, while also adhering to COVID 19 protocols and guidelines.		
	Community Care believes that this intervention will improve aftercare through the activities of Community Based Care Management, which includes encouraging the use of preventative services, mitigating social determinants of health barriers, reducing health disparities, improving behavioral health outcomes, and increasing partnerships with Community-Based Organizations.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Community HealthChoices:** Community HealthChoices is Pennsylvania's mandatory managed care program for dually eligible individuals (Medicare and Medicaid) and individuals with physical disabilities. Community HealthChoices was developed to enhance access to and improve coordination of medical care as well as to create a person-driven, long-term support system in which individuals have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. Community HealthChoices implementation officially completed with the last phase starting January 2020. All zones are now active with Community HealthChoices. There are regular meetings with the 3 Community HealthChoices plans across Pennsylvania to identify challenging cases, barriers, training and	Community HealthChoices implemented January 2019 - January 2020 Community HealthChoices coordination occurs as part of the Care Management daily activities	Community Care hosts and participates in quarterly statewide partner meetings with the other Community HealthChoices managed care organizations in Pennsylvania to identify challenging cases, barriers, training, data sharing, and information/resource sharing. Community Care collaboratively shares information regarding 30-day follow up and inpatient admissions with Community HealthChoices. Likewise, data is shared with us regarding physical health data.

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	information/resource sharing. These continued collaboration activities are led by Community Care's Director of Integration.		
	There are currently 144,650 Community HealthChoices members receiving behavioral health services. In 2020, the monthly inpatient mental health utilization of Community HealthChoices fluctuated between 145 and 260 members per month. In fact, Community HealthChoices members accounted for 15% of Community Care's HEDIS qualified discharges. Data analysis indicates that HEDIS follow-up of our Community HealthChoices members is about 8 percentage points below the aggregate.	2020	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision. Template entry is monitored as an activity of supervision and feedback and corrective action occurs with care managers, as necessary.
	This data was analyzed to determine barriers related to Community HealthChoices members receiving timely aftercare following an inpatient mental health admission. Community Care identified the following factors to decreased FUH rate in Community HealthChoices members: • Aftercare services are not billed through Medicare as the members' primary insurer, • Many older individuals receive behavioral health services through primary care, and, • Many Community HealthChoices members have existing home and community services. To support these findings, Community Care was able to access some Community HealthChoices Medicare data to evaluate the penetration of behavioral health services with both payers (Medicaid and Medicare) combined. In 2020, Community HealthChoices members in Allegheny County had a penetration rate of 11% when only analyzing Medicaid claims. When Medicare claims were added, 61% of Allegheny Community HealthChoices members had a behavioral health claim.		
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care. Unfortunately, Community Care's ability to impact our HEDIS FUH rate for Community HealthChoices is limited due to dual eligibility factors.		
Providers (2.2) Inpatient mental health providers	**Co-Occurring Disorder Initiative –** (HCAL) Allegheny County Department of Human Services, Allegheny HealthChoices Initiative, and Community Care, in close	2015 – Present Ongoing, Quarterly	To monitor progress with co-occurring disorder capability, providers share updates during the quarterly provider

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have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services	collaboration with Case Western Reserve University's Center for Evidence-Based Practices, established the Co-Occurring Disorders Initiative in Allegheny County in 2015 to increase ambulatory providers' competencies with co-occurring disorder treatment within the existing administrative and regulatory structures. The Dual Diagnosis Capability framework for Mental Health Treatment and Addiction Treatment guide the initiative, which includes a baseline Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment assessment, quality improvement planning, technical assistance, training, and provider meetings to discuss progress.		meetings and discuss successes and challenges in further detail during technical assistance sessions. Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment re-assessments are completed upon request to monitor direct changes in provider competencies.
	In 2022, participating outpatient programs have the opportunity to earn an enhanced rate on relevant billing codes for two years for achieving identified thresholds of co-occurring treatment capability. The purpose of this process is to further incentivize and support quality improvement of ambulatory services in their capacity to serve individuals with co-occurring mental health and substance use disorders concurrently. Eligibility for the enhanced rate is based on scores on a new Dual Diagnosis Capability for Addictions Treatment or Dual Diagnosis Capability for Mental Health Treatment. Five programs across four providers (four outpatient substance use, one outpatient mental health) made the decision to undergo the review process in 2022.	2022	
	Community Care feels that the ability to access co-occurring disorder treatment affects our members' recovery and directly and indirectly impacts the follow-up of our co-occurring members from inpatient mental health.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues	**Enhanced Discharge Planning:** Daily Care Management activities focus on members with readmissions and involves review of daily admissions (Care Management reviews on Monday include weekend admissions.) Care Managers conduct a semi-structured interview, using motivational approaches, problem solving, and case management follow-up activities to ensure members received needed aftercare.	Ongoing Intervention occurs as part of the Care Management daily activities	During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time, as needed, with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care
	In October 2019, Community Care expanded the interview process. Interviews now include children as well as other priority members, for example, members who may have readmitted over the standard 30-day readmission timeframe (i.e., readmitted after	Process expanded in October 2019 and again February 2020	

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People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	35 days) or who may have other barriers related to other social determinants. This expansion may grant opportunity for this intervention to serve as prevention. In February 2020, Community Care further expanded the interview process to include members who were admitted for the first time to an IPMH. Also, 3.5 and 3.7 levels of care were added for the interviews. All contracts used the same readmission interview template to identify reasons presenting for admission and to assist in discharge planning.		Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments as well as presented at the Care Management Leadership meeting. Care Management interventions are targeted and adjusted, as necessary, per the data.
	During these interviews, Community Care actively gathers information if members attended follow up, reasons why follow-up may have not been attended, if discharge plan was understood, etc. Care Managers provide assistance in real time, as needed, with barriers identified. A report, which reflects both contract-specific and aggregate data related to the Enhanced Discharge Planning and High-Risk Care Management interviews, is compiled annually. These reports are shared with Quality and Clinical Departments as well as presented at the Care Management Leadership meeting. Care Management interventions are targeted and adjusted, as necessary, per the data.		Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.
	Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate	**High-Risk Care Management interventions:** Members can be deemed high risk for reasons such as clinical presentation, treatment history and response, or as an identified at-risk population. High-Risk members require a longitudinal intensive level of intervention. Comprehensive Care Management strategies are initiated to ensure service linkage, coordination, and timely delivery of quality health care for those at-risk for significant symptoms and members who have difficulty connecting to aftercare treatment services. Community Care strives to ensure that recovery principles and tenure in the community are at the core of High-Risk care management. High-Risk Care Managers met with members face-to-face on the unit to identify these barriers, address concerns, coordinate with inpatient staff around member needs, and help with discharge	Ongoing Intervention occurs as part of the Care Management daily activities	Clinical Supervisors utilize a standardized tool to rate Care Managers related to interventions performed with members. This template includes a question related to follow-up ("The Care Manager review shows evidence of robust discharge planning, for example awareness of factors leading to readmission and/or potential triggers for readmission"). Feedback and corrective actions are taken with care managers, as necessary.

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	planning. Starting in March 2020, due to concerns surrounding the COVID-19 pandemic, Care Managers implemented both telephonic or virtual interviews to capture the data and intervene, as necessary. High-Risk Care Managers encourage coordination with family or friends as part of their interaction with members. High-Risk Care Managers address social determinants with the member and the inpatient staff and coordinate with relevant agencies during the inpatient stay.		
	In 2021, Community Care developed High-Risk Care Management Best Practice Guidelines to aid in standardization of High Risk practices.	2021	
	Community Care uses clinical groupings to identify members who are receiving enhanced care management activities such as High Risk or Complex Care Management. Data analysis of the 2020 HEDIS FUH data indicates that members who were in these clinical groupings were 9 to 10 percent more likely to have follow-up within 30-days. At this time, we are considering this data preliminary as Care Managers were not always consistently using the clinical grouping to identify members receiving these interventions. We believe that the data for 2020 does not reflect all the possible members who were receiving these enhanced interventions. In 2021, Care Managers were asked to consistently use clinical grouping selection to identify members with enhanced Care Management interventions. A report was developed for Care Management to track the consistency of the selection and a job-aide was developed.	2021	Community Care developed an RCA Monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement. Specific to Care Management consistently using clinical groupings, this report is reviewed by and updated on a monthly basis.
	Community Care believes that this intervention improves HEDIS FUH by assisting members to overcome barriers to aftercare.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission	**Inpatient Mental Health Provider Quality Improvement Activities:** Community Care conducted its annual review of the entire inpatient mental health provider network on February 21, 2021, and based on this review, six distinct providers were selected to participate the 2021 Inpatient Mental Health Quality Improvement Activity. Community Care's Inpatient Mental Health Quality Improvement Activity process has typically been composed of staff interviews, a facility tour, discussion with executive leadership staff, and the completion of member record	This process was implemented in March of 2019 as an annual activity. Prior to 2019 inpatient mental health activities occurred on a contract specific schedule.	Each year's activities are reviewed at the Board Quality Improvement Committee and each contract's Quality and Care Management Committee meetings.

<table>
<tr><th colspan="4">RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)</th></tr>
<tr><td>among members</td><td>reviews. However, given the current COVID-19 pandemic and increased restrictions across the state, Community Care's Quality Department made modifications to this year's 2021 Inpatient Mental Health Quality Improvement Activity methodology with the suspension of onsite activities; record reviews were completed via mail, secure email, fax, or remote electronic medical record; facility tours were not completed but staff interviews were done virtually. During a record review, if a provider did not score within the designated benchmark for the Discharge Management Planning composite score, which includes "Follow-up appointment scheduled within 7 days, including all required elements," a Quality Improvement Plan would be requested from the provider.</td><td></td><td></td></tr>
<tr><td></td><td>Update to review results are as follows.
Indicator: Notice to aftercare providers within 1 business day of inpatient discharge including information about discharge and medications
<table>
<tr><th>2019 Rate</th><th>2020 Rate</th><th>2021 Rate</th></tr>
<tr><td>69%</td><td>73%</td><td>70%</td></tr>
</table>
Indicator: Evidence of a Completed Discharge Management Plan
<table>
<tr><th>2019 Rate</th><th>2020 Rate</th><th>2021 Rate</th></tr>
<tr><td>96%</td><td>100%</td><td>95%</td></tr>
</table>
Indicator: Follow Up appointment scheduled within 7 days, including all required elements
<table>
<tr><th>2019 Rate</th><th>2020 Rate</th><th>2021 Rate</th></tr>
<tr><td>69%</td><td>91%</td><td>80%</td></tr>
</table>
For record review indicators around discharge planning, the composite score was 85%.
Providers who did not meet goal for any record review indicator were asked to complete a quality improvement plan. This resulted in all 6 providers submitting a quality improvement plan for the 2021 Inpatient Mental Health Quality Improvement Activities. Although this measure is specifically for 7-day follow-up, improvement in the 7-day rate will inherently improve the 30-day follow-up rate.</td><td>2021</td><td>This is an annual activity that will be completed again in 2022.</td></tr>
</table>

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, addressing engagement issues, and physical health needs.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Integrated Care Plan:** In alignment with Pennsylvania Department of Human Services goal for greater integration and coordination of behavioral and physical health services, Community Care engages in care coordination with physical health plans and documents these activities in an Integrated Care Plan. This Integrated Care Plan, or member profile, is used for the collection, integration and documentation of key physical and behavioral health information that is easily accessible. Community Care identifies members for inclusion in the project based on diagnostic history. Members are stratified to either high or low behavioral health need using a Community Care defined algorithm. The behavioral health stratification file is shared with corresponding physician health plan. The physical health plan adds their physical health high/low stratification completing the 4-quadrant analysis. Combined behavioral health/physical health member file is returned to Community Care. Process completed monthly to capture new, changed or deleted information. Data is uploaded to our clinical platform on the Integrated Care Plan Template; the electronic template documents the member's physical health and behavioral health needs, dates of coordination with respective plan, referral reason and intervention. The template is completed primarily following telephone coordination with the physical health plan representative, either ad hoc or during planning clinical rounds Care managers will have the ability to view the members' tiers on the Clinical Group tab.	Ongoing Intervention occurs as part of the Care Management daily activities	The number of completed Integrated Care Plans is tracked and presented annually to the Quality and Care Management Committees. Goals related to Integrated Care Plans completed have been consistently met. As part of the activity, Community Care monitors Integrated Care Plans completed for members with an inpatient admission. The measurements around this activity focus on integrating physical and behavioral health care.
	Community Care's goal for each contract is 0.42% of the 2017 averaged monthly Medicaid eligible will have an Integrated Care Plan including physical health and behavioral health data reviewed by both managed care organizations. The number of completed Integrated Care Plans is tracked and presented annually to the Quality and Care Management Committees. Goals related to Integrated Care Plans completed have been consistently met. Of note, there were 8,494 Integrated Care Plans completed in 2021.	2017-2021	

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
	According to an analysis of the 2020 HEDIS FUH data, 45% of HEDIS qualified discharges had an Integrated Care Plan. The follow-up rates for these members were 2 percentage points higher for 30-day.	2020	
	Community Care believes that this intervention improves aftercare by assisting members to overcome barriers to aftercare related to physical health needs and coordinating care.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members ***Provisions (3.2)*** Medication appointments with psychiatrists are often hard to secure in a timely manner	**Inpatient Mental Health Shared Savings Value-Based Payment Arrangement:** Community Care and its primary contractors implemented a shared savings value-based payment model for inpatient mental health facilities focused on 7-day ambulatory follow-up and 30-day readmission. While those two areas of focus improve community tenure and encourage treatment in the least restrictive care for our members, reduction of readmission reduces the per cost per member for care. These efforts result in not only better outcomes for members but also allow for savings dollars to be shared back with inpatient mental health facilities. Providers' meeting goals on the measures receive a portion of the savings in the form of a rate enhancement in the future year.	Initiated in January 2017, ongoing growth and development.	Monitoring for this intervention is driven by value-based purchasing arrangements. Measures are 7-day follow-up rate and 30-day readmission rate. So far, the provider's success in meeting goals related to follow-up have not been consistent. Ongoing activities related to Value-Based Purchasing arrangements are occurring as expected and will continue within Community Care, with providers given performance reports via Community Care's portal on a monthly basis. Payments to providers are made according to performance.
	Inpatient mental health value-based purchasing activities with analyses in 2021 consisted of 8 inpatient providers. All 8 providers met the goal for 7-day follow-up. There were 44 measures (8 providers measured for multiple contracts) analyzed in 2020 for 7-day follow-up and 6 met the goal. Seven providers were analyzed for 30-day follow-up in 2020 and 3 met goal.	2020 & 2021 Analyses	
	Transition to Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement: In 2021, the Inpatient Mental Health Shared Savings model evolved into a shared savings model that includes the ambulatory services system and focuses on the successful transition from inpatient to ambulatory services and the coordination of the two service systems to maintain members in the community. Activities included a Learning Collaborative for providers to increase collaboration and knowledge of best practices at both levels of care. Measures will include 30-day readmission and 7-day follow-up, but providers will also be required to participate in regional collaborative activities. This Value Based model will also include a community-based organization in the region that will address social	2021	Community Care believes that the addition of ambulatory services and evolvement into a shared savings model will encourage providers to be more proactive about actively addressing barriers to aftercare. Rates will be analyzed for follow-up again in 2021 to evaluate effectiveness.

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
	determinants of health that impact members being admitted or have the potential to be admitted to inpatient mental health services. Although this measure is specifically for 7-day follow-up, improvement in the 7-day rate will inherently improve the 30-day follow-up rate.		
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers to individualized discharge planning, aftercare, and addressing engagement issues.		
People (1.1) Specific to Black/African American members Research shows 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 ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome	**Mental Health First Aid–** (HCAL) Allegheny HealthChoices Initiative and Allegheny County Department of Human Services collaborate to facilitate the Southwestern Pennsylvania Mental Health First Aid Collaborative, which was founded in 2009 to maximize the positive impact of Mental Health First Aid trainings in Allegheny and surrounding counties. Mental Health First Aid is an evidence-based public education program that trains individuals to be able to recognize and provide initial support to those who may be experiencing early, worsening, and crisis-level mental health and substance use challenges. The training has been tailored to meet the needs of several populations, including adults learning how to assist other adults (Adult Mental Health First Aid) and adults learning how to assist youth (Youth Mental Health First Aid). Trainings can occur in-person, virtually, or in a blended capacity. The Southwestern Pennsylvania Mental Health First Aid Collaborative consists of over 190 certified Mental Health First Aid instructors from over 80 organizations, including Steel Smiling, Allegheny County Department of Human Services Offices, and a range of behavioral health and social services providers. Trainings are held for members of diverse communities and organizations in Allegheny County, including areas with majority Black/African American populations and community organizations serving those communities. Allegheny HealthChoices Initiative coordinates regional instructor certification trainings and Mental Health First Aid trainings for HealthChoices members and those who serve them, in addition to other populations through other funding sources, such as the SAMHSA Emergency Response Grant.	2009 – Present Ongoing	Allegheny HealthChoices Initiative maintains a database related to Southwestern Pennsylvania Mental Health First Aid Collaborative trainings and facilitates additional data requests to the National Council for Behavioral Health, the organization that houses Mental Health First Aid program in the United States. Outcomes related to Mental Health First Aid training are provided upon request, including the number of trainings held by type, number of participants trained, and number of trainers.

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
barriers associated with attending			
People (1.1) Specific to Black/African American members Research shows 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 ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience health inequity in behavioral health treatment	**Minority Benchmarking Workgroup:** (HCAL) In 2020 Community Care developed a Minority Benchmarking Workgroup to identify and address disparities in Substance Use Disorder Treatment. The workgroup started with Allegheny County, as Community Care's most diverse contract, with the goal of developing interventions that can be replicated in other contracts. The workgroup found that in Allegheny County Black or African American members are less likely to receive Medicated Assisted Treatment as a treatment.	2020 and ongoing	This workgroup meets monthly to discuss data and finding.
	The Minority Benchmarking Workgroup is proposing interventions that focus on outpatient substance use treatment providers and increasing the percentage of minority members on medicated assisted treatment through education.	2021-2022	Once interventions are finalized in conjunction with stakeholders, the workgroup will develop a method to track and report outcomes for the project.
	Proposed interventions to be reviewed with Allegheny County and Allegheny HealthChoices, Inc. for consideration and feedback.	2022	
	Community Care feels that the ability to access medication assisted treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health facilities.		
People (1.1) Specific to Black/African	**Network Availability of Black/African American practitioners and culturally competent providers:** Community Care asks practitioners if they would like to disclose their race/ethnicity or	Ongoing	Community Care will track the number of practitioners and facilities disclosing a specializing in minority population and

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
American members Research shows 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 ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience health inequity in behavioral health treatment ***Provisions (3.1) Specific to Black/African American members*** There is a shortage of Black/African	religion to be used during our referral process, and all providers are asked if they have any area of specialization during the credentialing and re-credentialing process. Providers who choose to disclose this are identified within Community Care's network accordingly. When members call Community Care's Member Line requesting same-race practitioners or practitioners specializing in minority populations, Customer Service Representatives are able to see this information when searching for providers in the member's region.		practitioner race/ethnicity/religion through multiple projects occurring around network availability. These factors are consistently assessed when considering network expansion.
	In 2021, Community Care surveyed the provider network, encouraging the disclosure of race, ethnicity, religion, or specializations to improve the accuracy of information. As of February 2022, 70% of Community Care's contracted practitioners who have gone through recredentialing (3 year cycle) identified their race. Of the 70% (675) who self-identified 7% (44) identified as Black or African American. Race/ethnicity and religion are not tracked for facility credentialed providers, as this information is dependent on who is employed by the facility at the time of credentialing and is subject to change. For specializations, 96 practitioners and 37 facilities responded to having specialized knowledge and cultural competency in the Black/African American population.	2021	Updates for this intervention will be kept by Community Care's Network Department to ensure movement and reportability.
	This information is not available on the Provider Directory at www.ccbh.com. Community Care will explore the option of adding this information to applicable providers in the Provider Directory with possible search capabilities when and if a method for directory updates is established to improve accuracy. Community Care will continue to work with providers to get race, ethnicity, language, and specialization information during the credentialing and re-credentialing process to have the most accurate information as possible in order to assist members in finding culturally competent care.	2022-2023	
	Community Care feels that it is essential for members to receive culturally competent care. Encouraging providers to disclose race, ethnicity, and/or specialization(s) assists members to make informed decisions when choosing a treatment provider. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
American treatment providers and there are limitations on identifying culturally competent care			
Providers (2.2) Inpatient mental health providers have difficulty getting new members into medication assisted treatment programming and other substance use disorder treatment services ***Provisions (3.2)*** Medication appointments with psychiatrists are often hard to secure in a timely manner	**Network Expansion:** Community Care is continually seeking to expand the network, as appropriate, to best meet the needs of members. Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Community Care's Network Department adds providers to the network that offer non-traditional hours when they are available. Community Care also collaborates with providers within the existing network to ensure after-hour appointments are offered and accommodated. Emphasis for non-traditional hours have been given towards medication assisted treatment providers. Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule.	Ongoing part of operations	Each individual contract provider relations representative brings potential providers to clinical operations meetings for review and vetting to ascertain the necessity of adding this provider to the network. These meetings occur at least monthly, with most occurring bi-monthly. Emphasis for non-traditional hours have been given towards medication assisted treatment providers. Non-participating provider agreements are completed, as necessary, with consideration to bring providers in that can best accommodate a member's schedule. Community Care also monitors all complaints that may be related to a provider's unwillingness to accommodate a member's schedule. Each complaint is investigated thoroughly, with a focus on the member receiving the services, as necessary.
	In 2021, various network expansion occurred, including the addition of new providers and expansion of existing providers through additional locations and levels of care such as: • Inpatient Mental Health • Residential Substance Abuse treatment • Individualized Behavioral Health Services • Telepsychiatry • Clozaril Support	2021	
	Community Care feels this intervention has a positive impact on HEDIS FUH rate by improving the availability of appropriate levels of care and provider options following an inpatient mental health discharge.		

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Outpatient Mental Health Quality Record Reviews:** Community Care conducts Record Reviews for ambulatory providers when these levels of care are identified as a contract priority and planned in the annual Quality Work Plan. One of the indicators often assessed during these reviews is "If member had an inpatient mental health admission during the course treatment, post-hospital follow-up occurs within 7 calendar days." Providers with a sufficient sample who do not meet goal are asked to complete a quality improvement plan on how to improve.	Annual, as determined by each contract's Quality Work Plan.	Each year's reviews are reviewed at each contract's Quality and Care Management Committee meetings.
	Community Care feels that this intervention impacts aftercare by asking providers to assess their barriers for providing timely follow-up.		
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Performance Issues:** Community Care tracks aftercare appointments from all inpatient discharges as part of routine Care Management functions. The Quality Management Department collates this data to determine if members have aftercare appointments prior to discharge and that those appointments are within 7-days of the discharge date. The data is monitored on a monthly basis and providers who develop a trend of provider performance issues, a quality improvement plan is requested, and the trend is monitored for resolution. This intervention applies to both inpatient and aftercare service providers. Although this measure is specifically for 7-day follow-up, improvement in the 7-day rate will inherently improve the 30-day follow-up rate.	Suspended	Community Care's Quality Management Department reviews Provider Performance Issues on a monthly basis to track and identify trends. Quality Improvement Plan requests, update requests, or notifications are sent on a monthly basis based on multiple factors, including length of trend, past trends, or past requests.
	Additional information on Provider Performance Issues can be found on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/information-and-resources/provider-performance-issues		
	This activity has been suspended since May 2020 due to COVID-19. Community Care will resume this intervention when OMHSAS lifts the temporary suspension of specific authorization regulations, (bulletin 1135).	This activity has been suspended since May 2020 due to COVID-19. Community Care will resume this intervention when OMHSAS lifts the temporary suspension of specific authorization	
	Community Care feels that this intervention impacts our HEDIS follow-up rates by addressing deficiencies at the provider level.		

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
		regulations, (bulletin 1135).	
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Performance Standards:** Community Care issues Performance Standards which are intended to be best-practice standards that providers will use to design and assess their programs and that Community Care will use to assist with assessment of the quality of services. Performance Standards are published for providers on Community Care's website at https://providers.ccbh.com/clinical-and-innovative-resources/performance-standards Community Care has issued Performance Standards specific to inpatient and outpatient levels of care which outlines expectations around aftercare planning and aftercare appointments. Community Care feels that establishing performance standards supports interventions by clearly outlining the expectation of timely follow-up in documents regularly shared with the provider.	Ongoing and updated in 2019	Community Care directs providers to the Performance Standards, and/or distributes copies of performance standards as part of many company activities, as appropriate, such as provider meetings, requests for quality improvement, and during credentialing. Community Care's Quality Management Department conducts scheduled and ad hoc record reviews of provider records to assess adherence to Performance Standards. Indicators around discharge planning are included in tools for all levels of care and rates are compared over time in annual quality and care management committee meetings for each contract. Community Care additionally monitors the expectation of 7-day follow-up from inpatient mental health through Provider Performance Issues (outlined above).
People (1.1) Specific to Black/African American members Research shows Black/African American members are less likely to engage and complete treatment, compared to their	**Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders:** In 2020 Community Care, along with primary contractors and OMHSAS, initiated a company-wide Performance Improvement Plan. The Aim of this Performance Improvement Plan is to significantly slow and eventually stop the growth of substance use disorders prevalence among HealthChoices members while improving outcomes for those individuals with substance use disorders. Five related measures have been identified including: 1) Follow-up after high-intensity care for substance use disorder; 2) Substance use-related avoidable readmissions; 3) Mental health-related avoidable readmissions; 4) Psychosocial interventions and pharmacotherapy for opioid use disorders; and 5) Psychosocial interventions and	2020	

<table>
<tr><th colspan="4">RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)</th></tr>
<tr><td rowspan="2">White counterparts, due to negative perceptions of treatment and reluctance to acknowledge symptoms

People (1.3)
Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members

Providers (2.1) Specific to Black/African American members
Black and African Americans experience health inequity in behavioral health treatment

Providers (2.2)
Inpatient mental health providers have difficulty getting new members into medication</td><td>pharmacotherapy for alcohol use disorders. In order to positively impact these measures, Community Care will be implementing the Cascade of Care Model framework, which is implemented in stages, beginning with Stage 1 or Intercept. Stage 2 or Engagement as well as Stages 3 & 4: Retention will then be implemented. In November 2020, baseline data for all five measures was established.</td><td></td><td></td></tr>
<tr><td>Community Care established targeted interventions for the Cascade of Care Intercept Stage 1 as follows:
•Warm Hand Off: is the linking of a member with an appropriate treatment provider following a substance use disorder related event. The Warm Hand Off intervention focuses on increasing the percent of members when presenting at Physical Health hospitalization or emergency departments who initiate substance use treatment including medication assisted treatment for alcohol use disorder and medication assisted treatment for opioid use disorder over 36 months, by bridging the gap between physical health and substance use disorder treatment systems. Warm Hand Offs are done by peers, case managers of Single County Authorities, Centers of Excellence, or other contracted providers.
•Telehealth Bridge Clinic: aims to increase the rate of billed telehealth claims for prescribing medication assisted treatment for members with opioid use disorder and alcohol use disorder during or immediately following an inpatient physical health hospitalization or emergency department visit through untapped prescribing services via telehealth designed to engage individuals into substance use disorder treatment. This intervention has a 36 month focus.
•Federally Qualified Health Center Learning Collaborative: Please see the Collaborative Care at Federally Qualitied Healthcare Centers intervention above.
These interventions are designed to impact the five performance measures as well as the overarching Performance Improvement Plan Aims statement and objectives.
OMHSAS, as part of this Performance Improvement Plan required two non-clinical, population health activities, which is new for this process:
The Anti-Stigma Campaign, known as Community Care’s Anti-Stigma Resources and Education Campaign (CCARE) was</td><td>Project implementation, including interventions started at the beginning of 2021 and will continue through 2023, with the last update to the project to be reported in September 2024</td><td>Updated reports to the Performance Improvement Plan are submitted to County Oversights and OMHSAS/IPRO on a quarterly basis along with an annual submission.

In addition to the five performance measures, Community Care annually monitors three indicators to assess the success of the interventions: utilization of medication assisted treatment, overall substance use disorder penetration rate, and PA Death by Drug Overdose Rate.</td></tr>
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assisted treatment programming and other substance use disorder treatment services	implemented July 1, 2021. The campaign is designed to reduce stigma for seeking help for substance use disorders resulting in more members engaging in substance use disorder care. The campaign includes anti-stigma education, targeted media posts, webinars, and community outreach and is designed to add to existing statewide substance use disorder anti-stigma efforts rather than duplicate existing programs such as the Life Unites Us and Shatterproof campaigns. The campaign has a focus on Black/African American racial disparities and builds upon recent substance use disorder education and collaboration efforts with community partners and others to expand educational anti-stigma programs. Community Care's Anti-Stigma Resources and Education Campaign resources are posted to the Community Care website along with a brief survey of stigma. This campaign includes Barber/Beauty Shop Project which educates Black/African American barbers and stylists in Pittsburgh area on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. The **Community Health Worker Outreach** intervention (implemented July 1, 2021) focuses on increasing follow up and decreasing readmission through outreach by a Community Health during or immediately following a withdrawal management or inpatient substance use treatment stay to educate members (at least 13 years of age) on care options, facilitate referral and connection to behavioral health services or other community supports. Embedded within this intervention is a mandatory cultural awareness training for all Community Health Workers. Staff training in cultural awareness will improve the work that we do and how we interact with all our members. Sensitivity to different cultures will increase our understanding of help seeking behavior, access issues, and resources available to members.		
	Community Care feels that the ability to access ambulatory substance use disorder treatment affects our members' recovery and likely impacts the follow-up of our co-occurring members from inpatient mental health. Members being enrolled in medication assisted treatment following an inpatient admission may prevent a readmission to a residential level of care before mental health aftercare can happen.		

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
People (1.3) Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	**Provider Benchmarking:** Community Care distributes annual Provider Benchmarking reports. Reports, which include data related to follow-up after inpatient hospitalization, are sent to providers. Provider network averages are also given for comparison purposes. Providers whose members have not received timely follow-up care are educated about Community Care's expectation of timely follow-up care and its importance to the member's mental health care.	Ongoing activity	The activities of each year are developed by a workgroup that meets every other week. Feedback and updated rates are used to determine the most appropriate action to facilitate change. This activity is reported annually at the Quality and Care Management Committee meetings for each contract and at the Board Quality Improvement Committee. The Provider Benchmarking Publication is annual.
	Starting in 2022, Community Care will be aligning Provider Benchmarking Publications with Value-Based Purchasing arrangements to publish the previous year's results. See IPMH & Ambulatory Provider Value-Based Payment Arrangement intervention listed above. This is to ensure consistency in rate reporting to providers and to meet Appendix U requirements.	The 2022 publication is tentatively set for September 1, 2022.	Activity monitoring is captured in the Inpatient Mental Health & Ambulatory Provider Value-Based Payment Arrangement intervention listed above.
	In 2022, Community Care will establish a new approach of intervention to assist providers who are consistently not meeting goal.	2022	
	Community Care feels that this activity assists in addressing barriers to aftercare experienced by members and providers by defining expectations, providing education, and asking providers to think creatively about overcoming obstacles.		
People (1.5) Some members have competing physical health needs which makes setting up aftercare difficult	**Regional meetings with Physical Health Managed Care Organizations:** Community Care participates in quarterly regional collaboration meetings across the state to collaborate with the physical health managed care organizations Special Needs Units to identify those individuals with complicated health needs and to coordinate all services.	Ongoing practice	Monitoring occurs within the meetings, as needed and as identified in the discussion.
People (1.1) Specific to Black/African American members	**Social & Racial Justice Steering Committee activities:** The Social & Racial Justice Steering Committee was developed in 2021 to develop interventions to address inequities in five categories - Provider Professional Development, Internal Professional Development, Member Level Advocacy, Human Resource	2021 and ongoing	Internal reports and monitoring occur on a weekly basis as standing agenda items on reoccurring meetings with Senior Management.

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
Research shows 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 ***Providers (2.1) Specific to Black/African American members*** Black and African Americans experience health inequity in behavioral health treatment	Interventions, Community, and Policy. Workgroups were formed, including staff company-wide to address activities in the five categories. These workgroups identify sources for education and training to be shared internally and with stakeholders around inclusion and cultural diversity.		
	Activities for 2021 in these five areas included: • Providers were surveyed to identify detailed information in order to refer members to requested provider type. • National Alliance on Mental Illness released a list of Black/African American Providers in Allegheny County; Community Care made outreach to providers not already contracted inquiring interest in joining the network. • As part of the Prevention, Early Detection, Treatment and Recovery for Substance Use Disorders Initiative's Anti-Stigma Campaign, the Committee began development of a Barbershop/Beauty Shop initiative that will focus on training Black/African American stylists and barbers and stylists in Pittsburgh area on how to talk to clients about suicide, substance use disorders, and other behavioral health disorders, and how to link clients to treatment resources. • All Community Care employees were required to take Culturally Competent Skills and Behaviors training. • An internal Social and Racial Justice book club was started for all staff to learn about social and racial issues and meet to discuss and learn from other's perspectives.	2021	Community Care tracks interventions completed by this group and how to best measure effectiveness based on each intervention. We anticipate that the planned interventions (stakeholder education, training on inclusion & cultural diversity and human resource interventions) will have an impact on the gap in disparities seen among our Black/African American population with inpatient episodes and increase the number of providers in the Community Care network who will seek specialization in minority populations.
	Planned activities for 2022 include: • Development of a Social and Racial Justice Advisory Board. • Provider trainings on topics of social and racial justice, diversity, and inclusion. • Analyzing Community Care staff demographics to determine disparities and identify strategies to address. • Internal staff trainings related to social and racial justice, diversity, and inclusion. And to start this off, all Community Care Customer Service, Care Management, and Quality staff were required to take "A Culture of Inclusion and Belonging" training in early 2022.	2022	

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
	Community Care believes that this intervention will improve aftercare by identifying issues across the system and developing companywide interventions to impact inequities.		
Providers (2.1) Specific to Black/African American members Black and African Americans experience health inequity in behavioral health treatment ***Provisions (3.1) Specific to Black/African American members*** There is a shortage of Black/African American treatment providers and there are limitations on identifying culturally competent care	**Targeted Accessibility Analysis (formally Identifying gaps in treatment availability for Black/African American members using GEOAccess):** In 2021, Community Care developed a Targeted Accessibility Analysis to identify gaps in same-race or culturally competent treatment availability for our Black/African American members. Using GEOAccess Community Care plots geographical information regarding the drive time or the distance members in rural and urban locations must travel to get to a specific type of provider. We apply member race/ethnicity information from DHS enrollment data to their geographical location. A second layer of geographical information is applied for service locations of providers who have voluntarily identified themselves as Black/African American, and yet a third layer for providers who have voluntarily identified themselves as specializing in cultural competency. This data shows gaps in same-race or culturally competent providers reasonably accessible to our Black/African American enrollees. Once possible gaps in treatment availability have been identified, Community Care can develop specific regional interventions to address need.	2021	This report will be used in conjunction with other interventions addressing culturally competent care and when considering network expansion.
	The Targeted Accessibility Analysis has been applied to Allegheny County, which is Community Care's most diverse contract. The analysis entailed slicing the County into 4 sections and showed that less than half of Black/African American members had access to same-race or culturally competent care within the established standard of 2 providers within a 30 minute drive time.	2021	
	In 2022, Community Care will complete a Targeted Accessibility Analysis for Community Care contracts with disparities and provide an update to contract leadership regarding accessibility to culturally competent care for minorities.	2022	A workgroup meets quarterly to determine contracts for analysis and next steps.
	Community Care feels that it is essential for members to receive culturally competent care. This will impact Community Care's HEDIS FUH rates by linking members to providers most likely to positively impact their recovery.		
People (1.2) Many members	**Telehealth:** Telehealth allows behavioral health practitioners to provide clinical services, such as medication management,	2020	The availability of telehealth services is regularly monitored as part of network

have multiple barriers to attending aftercare like transportation, childcare, vocational schedule, legal issues, or housing issues ***People (1.4)*** Some members decline aftercare believing they don't need it, will not benefit from it, or can't overcome barriers associated with attending	assessment, diagnosis, and case management to members through two-way, interactive videoconferencing and telephone calls. Prior to the COVID-19 pandemic, Community Care supported these services on a limited basis, particularly for rural areas where drive time and transportation presented as a barrier. At the initiation of the pandemic in March 2020, OMHSAS loosened the regulations surrounding Telehealth to accommodate members utilizing behavioral health services. Members were able to attend appointments via telephone; they did not have to use video or screen sharing technology. Providers were able to expand the amount of services available to members. Preliminary results of the telehealth expansion include increased show rates, high member satisfaction, convenience for practitioners and members, and access to other settings and providers in real time. Satisfaction surveys were conducted by Consumer/Family Satisfaction Teams of 200 members from rural counties regarding their experiences of receiving services via telehealth. Almost all members who responded agreed or strongly agreed that their provider was able to "meet all of my behavioral health needs."		expansion requests and Network Adequacy Workgroup. Community Care has developed reports to monitor the use of telehealth services and regularly reminding providers to use telehealth place of service codes which was released in the March 16, 2020 Provider Alert, titled COVID-19 Update: Telehealth Services. The use of this code will be instrumental in Community Care obtaining accurate data. Provider Alert: https://providers.ccbh.com/uploads/files/Provider-Alerts/20200316-alert4-covid19.pdf
	Community Care analyzed the HEDIS FUH data for inpatient mental health discharges between March 16, 2020 and December 1, 2020. According to this information, almost half of all HEDIS qualified follow-up was delivered via telehealth. Specifically, 49% of 30-day appointments. These findings are driven by the quarantine status of the COVID-19 mitigation efforts in 2020 but is a positive indicator of future potential.		Additionally, Community Care developed a monitoring report that was completed in late 2021 to assess factors of HEDIS qualified discharges and analyze how the intervention is impacting 30-day HEDIS FUH rates. This data will be reviewed quarterly in 2022 for ongoing trend analysis and any additional opportunities for improvement.
	In accordance with OMHSAS directives in March 2020 when the disaster declaration was issued, services were permitted to be delivered via telehealth. The allowance of telehealth will remain in effect during the emergency disaster declaration authorized by Governor Tom Wolf. Four provider alerts have been issued for additional guidance on service delivery expectations and billing as well as Fraud, Waste, and Abuse. Community Care is also working to update telehealth service delivery post-COVID-19, including any OMHSAS/CMS guidance to support the continuation of services via telehealth platforms.		

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
	In 2021, the Consumer Action Response Team in Allegheny County added two questions to the member Satisfaction Survey related to telehealth with positive results. ▪ 80% of survey respondents (n. 1,374) indicated that telehealth made it easier for them to receive the services, ▪ 72% of survey respondents (n. 349) rated their experience with telehealth as satisfied or very satisfied. This data is promising when evaluating the overall effectiveness and satisfaction of telehealth services.	2021	
	It is anticipated that this service may be retained in the future, although more trainings would need to be offered to providers on topics related to telehealth, developing billing processes, and addressing current documentation procedures (e.g., how to obtain signatures on a treatment plan).		
Provisions (3.2) Medication appointments with psychiatrists are often hard to secure in a timely manner	**Telepsych:** Telepsychiatry allows behavioral health practitioners to provide clinical services to patients at remote, usually rural, locations through two-way, interactive videoconferencing, sparing both practitioners and patients the time and expense of long-distance travel. It allows members to access psychiatrists that would not otherwise be available to them. Patients may connect to a specialist via the telehealth network from their community healthcare facility.	2005 - ongoing	Community Care will continue to take an active role in expanding telepsychiatry and monitor its utilization via the number of members served and providers involved. Telepsychiatry services and related data is reported annually at Community Care's Board Quality Improvement Committee.
	Through December 2020, close to 31,054 unique members have been served via telepsychiatry, receiving psychiatric evaluations and medication management appointments. Approximately 73 providers currently utilize telepsychiatry services to better meet the needs of our members.	2020	
	Community Care feels that telepsych services permits a number of members to receive psychiatry services that wouldn't ordinarily be accessible, or much sooner than would be permitted in a traditional setting. This intervention positively impacts HEDIS FUH rates by increasing accessibility and reducing barriers.		
People (1.2) Many members have multiple barriers to attending aftercare like transportation,	**Utilization Management Provider Notification:** Notification processes are in place to inform Blended Case Managers, Family Based Mental Health Services, or other service providers as applicable, at the time of authorization of an inpatient admission for any of their members and to coordinate aftercare for children discharged to shelter placements.	Ongoing practice with process updated in 2020 Intervention occurs as part of the Care Management daily	Community Care's Clinical Department closely monitors this activity as part of Care Managements daily activities. Care Managers discuss and problem solve cases during supervision.

RCA for MY2020 underperformance: FUH 30–Day Measure (All Ages)			
childcare, vocational schedule, legal issues, or housing issues ***People (1.3)*** Inadequate discharge plans and/or issues with prescribed medications are among the top reasons for readmission among members	Community Care currently does not have a reliable method of collected the Provider Notification data on an aggregate level. At this time Community Care will continue to explore ways to aggregate this data.	activities	
	Community Care believes this activity impacts aftercare rates by involving other service providers in supporting members during and after IPMH stays.		

CCBH: Community Care Behavioral Health.

VII: 2021 Strengths, Opportunities for Improvement and Recommendations

The section provides an overview of CCBH's MY 2020 performance in the following areas: structure and operations standards, performance improvement projects, and PMs, with identified strengths and opportunities for improvement. This section also provides an assessment of the strengths and weaknesses of CCBH with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (as described in 42 CFR 438.310(c)(2)).

Strengths

- Review of compliance with MMC regulations conducted by the Commonwealth in RY 2018, RY 2019, and RY 2020 found CCBH to be fully compliant with Standards, Including Enrollee Rights and Protections and with Quality Assessment and Performance Improvement Program. This was a marked improvement from the previous year.
- CCBH's MY 2020 HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1) for the 6-17 age set population was statistically significantly above the HC BH Statewide rate for this age group.
- CCBH's MY 2020 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate was statistically significantly below the HC BH Statewide rate.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2018, RY 2019, and RY 2020 found CCBH to be partially compliant with the single category Grievance and Appeal Systems within Grievance System.
- CCBH's MY 2020 HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and 2) for ages 18-64 and 6+ fell below their respective HEDIS Quality Compass 75th percentiles.
- CCBH's MY 2020 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- Review of compliance with standards conducted by the Commonwealth in RY 2018, RY 2019, and RY 2020 found CCBH to be partially compliant with Network Adequacy.

Assessment of Quality, Timeliness, and Access

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

Table 7.1 details the full list of recommendations that are made for the MCO for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for the year. The PIP recommendations may include issues from prior years if they remain unresolved. Since 2020 was the baseline year, and the MCO met all requirements of the proposal stage, there are no recommendations applicable for this review period. For performance measures, the strengths and opportunities noted above in this section are determined for the current year, while recommendations are based on issues that were not only identified as opportunities for the current 2021 (MY 2020) year but were also identified as outstanding opportunities from 2020 (MY 2019).

Table 7.1: EQR Recommendations

Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	No recommendations	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness which suggests it should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities, and Centers of Excellence to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that ultimately impact quality, timeliness, and access to care, the MCO can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention.	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness which suggests it should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities, and Centers of Excellence to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that ultimately impact quality, timeliness, and access to care, the MCP can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness which suggests it should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities (SCAs), and Centers of Excellence (COE) to improve warm handoffs for initiation	Timeliness, Access

	and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that ultimately impact quality, timeliness, and access to care, the MCO can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention.	
Compliance with Medicaid Managed Care Regulations		
Grievance and appeal systems	CCBH was partially complaint with Grievance and appeal systems standard due to deficiencies associated with maintaining effective oversight of the complaint process. IPRO concurs with OMHSAS' recommendations, which include: ensuring consistent use of templates; reminding investigators and review panel members of the importance of closely reviewing information and evidence; reiterating with provider network the importance of providing information, documentation, and evidence requested by the CCBH Complaint Investigators; and ensuring sufficient documentation of outcomes of follow-up actions. CCBH should also ensure that both the member and the member's representative, if designated, receive a Grievance Acknowledgment Letter and written notice of the Grievance review decision on the correct Appendix H templates.	Quality, Timeliness, Access

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

VIII: Summary of Activities

Performance Improvement Projects

- CCBH successfully submitted a new PIP proposal on the PEDTAR topic for 2020.

Performance Measures

- CCBH reported all performance measures and applicable quality indicators for 2020.

Structure and Operations Standards

- CCBH was compliant with Standards, including Enrollee Rights and Protections and Quality Assessment and Performance Improvement Program and partially compliant with Grievance System. As applicable, compliance review findings from RY 2020, RY 2019, and RY 2018 were used to make the determinations.

Quality Studies

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

2020 Opportunities for Improvement MCO Response

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

2021 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CCBH in 2021 (MY 2020). The BH-MCO will be required to prepare a response in 2022 for the noted opportunities for improvement.

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Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for required PEPS substandards pertinent to BBA Regulations.[25]

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

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 68.7	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).

[25] In 2019, five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-specific PEPS substandards.[26]

Table B.1: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Substandard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	Other: Significant onsite review findings related to Standard 28.
Complaints and Grievances		
Complaints	Substandard 68.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 68.1.2	Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.
	Substandard 68.5	A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Substandard 68.6	Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 68.8	Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role.
Grievances	Substandard 71.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 71.1.2	Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.
	Substandard 71.5	A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with 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

Category	PEPS Reference	PEPS Language
		confidentiality requirement.
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements.
Executive Management		
County Executive Management	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/Family Satisfaction	Substandard 108.3	County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program.
	Substandard 108.4	The C/FST Director is responsible for: setting program direction consistent with County direction; negotiating contract; prioritizing budget expenditures; recommending survey content and priority; and directing staff to perform high quality surveys.
	Substandard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling, and have resulted in provider action to address issues identified.

[26] In 2019, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

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 RY 2020, 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 2020, 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 2020**	**RY 2019**	**RY 2018**
Care Management					
Care Management (CM) Staffing	1	0	0	0	1
Longitudinal Care Management (and Care Management Record Review)	1	0	0	0	1
Complaints and Grievances					
Complaints	5	0	0	0	5
Grievances	5	0	0	0	5
Denials					
Denials	1	0	1	0	0
Executive Management					
County Executive Management	1	0	0	0	1
BH-MCO Executive Management	1	0	0	0	1
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	0	3	0
Total	**18**	**0**	**1**	**3**	**14**

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

[2] The number of OMHSAS-Specific substandards that came under active review during the cycle specific to the review year.

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; CCBH: Community Care Behavioral Health; RY: review year. NR: substandards not reviewed.

Format

This document groups the monitoring standards under the subject headings Care Management, Complaints and Grievances, Denials, Executive Management, and Enrollee Satisfaction. The status of each substandard is presented as it appears in the PEPS Review Application (i.e., met, partially met, not met) and/or applicable RAI tools (i.e., complete, pending) submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the 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	-	Berks	Allegheny, Blair, CMP, Chester, Erie, Lycoming/Clinton, NBHCC, NCSO, York/Adams
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; CCBH: Community Care Behavioral Health.

One Primary Contractors associated with CCBH (Berks) was partially compliant with Substandard 7 of Standard 27 (RY 2018), and the rest of the CCBH Contractors were non-compliant.

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 non-compliant 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 2020. CCBH was compliant with 4 and partially compliant with 5 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; CCBH: Community Care Behavioral Health.

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	2020	All CCBH Primary Contractors	-	-

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

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 2018. 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; CCBH: Community Care Behavioral Health.

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: 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. f. Documentation of the County's reviews and/or audits of quality and accuracy of the major BH-MCO functions, including: 1) Care Management, 2) Quality Assurance (QA), 3) Financial Programs, 4) MIS, 5) Credentialing, 6) Grievance System, 7) Consumer Satisfaction, 8) Provider Satisfaction, 9) Network Development, Provider Rate Negotiation, and 10) Fraud, Waste, and Abuse (FWA).

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; CCBH: Community Care Behavioral Health.