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

2020 External Quality Review Report
PerformCare

FINAL

April 2021

Better healthcare, realized.

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

ISO
9001:2015
CERTIFIED

Table of Contents

Introduction 5
I: Validation of Performance Improvement Projects 7
Background 7
Validation Methodology 9
II: Validation of Performance Measures 10
Follow-Up After Hospitalization for Mental Illness 10
Readmission Within 30 Days of Inpatient Psychiatric Discharge 24
III: Compliance with Medicaid Managed Care Regulations 29
Methodology 29
Data Sources 29
Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for PerformCare 31
Determination of Compliance 31
Format 32
Findings 32
IV: Quality Studies 37
Certified Community Behavioral Health Clinics 37
Integrated Community Wellness Centers 41
V: 2019 Opportunities for Improvement – MCO Response 43
Current and Proposed Interventions 43
Quality Improvement Plan for Partial and Non-compliant PEPS Standards 43
Root Cause Analysis and Quality Improvement Plan 51
VI: 2020 Strengths and Opportunities for Improvement 63
Strengths 63
Opportunities for Improvement 63
Performance Measure Matrices 63
VII: Summary of Activities 66
Performance Improvement Projects 66
Performance Measures 66
Structure and Operations Standards 66
Quality Studies 66
2019 Opportunities for Improvement MCO Response 66
2020 Strengths and Opportunities for Improvement 66
References 67
Appendices 69
Appendix A. Required PEPS Substandards Pertinent to BBA Regulations 69
Appendix B. OMHSAS-Specific PEPS Substandards 75
Appendix C: Program Evaluation Performance Summary: OMHSAS-Specific Substandards for PerformCare Counties 77

List of Tables and Figures

Table 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years) ... 14
Figure 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years). ... 15
Figure 2.2: PerformCare Contractor MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years) that are Statistically Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years) ... 16
Table 2.2: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages) ... 17
Figure 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages). ... 18
Figure 2.4: PerformCare Contractor MY 2019 HEDIS FUH Follow-Up Rates (All Ages) that are Statistically Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (All Ages). ... 19
Table 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–17 Years) ... 19
Figure 2.5: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years). ... 20
Figure 2.6: PerformCare Contractor MY 2019 HEDIS FUH Follow-up Rates (6–17 Years) that are Statistically Significantly Different than HealthChoices (Statewide) MY 2019 HEDIS FUH Follow-up Rates (6–17 Years). ... 20
Table 2.4: MY 2019 PA-Specific FUH 7- and 30-Day Follow-up Indicators (All Ages) ... 21
Figure 2.7: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages). ... 22
Figure 2.8: PerformCare Contractor MY 2019 PA-Specific FUH Follow-Up Rates (All Ages) that are Statistically Significantly Different than HC BH (Statewide) MY 2019 PA-Specific FUH Follow-Up Rates (All Ages). ... 23
Table 2.5: MY 2019 REA Readmission Indicators ... 26
Figure 2.9: MY 2019 REA Readmission Rates for PerformCare Primary Contractors. ... 27
Figure 2.10: PerformCare Contractor MY 2019 REA Readmission Rates (All Ages) that are Statistically Significantly Different than HC BH (Statewide) MY 2019 REA Readmission Rates (All Ages). ... 28
Table 3.1: HealthChoices Oversight Entities, Primary Contractors and Counties ... 29
Table 3.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for PerformCare ... 31
Table 3.3: Compliance with Standards, including Enrollee Rights and Protections ... 32
Table 3.4: Compliance with Quality Assessment and Performance Improvement Program ... 34
Table 3.5: Compliance with Grievance System ... 35
Table 4.1: CCBHC Quality Performance compared to Statewide and National Benchmarks ... 38
Figure 4.1: Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care. ... 40
Figure 4.2: Comparison of CCBHC to Control Clinics on Child Patient Experience of Care. ... 40
Table 4.2: ICWC Annual and Quarterly Quality Measures ... 41
Table 5.1: BH-MCO's Responses to Opportunities for Improvement ... 44
Table 5.2: PerformCare RCA and CAP for the FUH 7–Day Measure (All Ages) ... 53
Table 5.3: PerformCare RCA and CAP for the 30-Day Measure (All Ages) ... 58
Table 6.1: BH-MCO Performance Matrix for MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge (Overall) ... 64
Table 6.2: MY 2019 PA-Specific 7- and 30-Day Follow-up after Hospitalization and MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (Overall) ... 64
Table 6.3: BH-MCO Performance Matrix for MY 2019 HEDIS FUH 7- and 30-Day Follow-Up After Hospitalization (All Ages) ... 65
Table 6.4: BH-MCO's MY 2019 FUH Rates Compared to the Corresponding MY 2019 HEDIS 75th Percentiles (All Ages) .. 65
Table A.1: Required PEPS Substandards Pertinent to BBA Regulations ... 69
Table B.1: OMHSAS-Specific PEPS Substandards ... 75

Table C.1: Tally of OMHSAS-Specific Substandards Reviewed for PerformCare 77
Table C.2: OMHSAS-Specific Requirements Relating to Care Management 78
Table C.3: OMHSAS-Specific Requirements Relating to Complaints and Grievances........ 78
Table C.4: OMHSAS-Specific Requirements Relating to Denials........ 79
Table C.5: OMHSAS-Specific Requirements Relating to Executive Management 80
Table C.6: OMHSAS-Specific Requirements Relating to Enrollee Satisfaction........ 80

Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA). The HEDIS Compliance Audit™ is a trademark of the NCQA. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). Tableau® is a registered trademark of Tableau Software.

Introduction

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

OMHSAS contracted with Island Peer Review Organization (IPRO) as its EQRO to conduct the 2020 EQRs for HC BH-MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO: PerformCare. 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 HealthChoices Behavioral Health (HC BH) Contractor and, in other cases, multiple Primary Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. In the PerformCare network, Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties formed on July 1, 2019 an HC Oversight Entity called Capital Area Behavioral Health Collaborative (CABHC). The Tuscarora Managed Care Alliance oversees the HC BH program for Franklin and Fulton Counties. On July 1, 2019, the Bedford-Somerset HealthChoices Oversight Entity changed contracts from PerformCare to CCBH.

Objectives

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

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

Report Structure

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

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Quality Studies
V. 2019 Opportunities for Improvement – MCO Response
VI. 2020 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, Information for Sections II and III of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO,

included a repeated measurement of two PMs: Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. The information for compliance with Medicaid Managed Care Regulations in section III of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity, when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. Section IV discusses the Quality Study for the Certified Community Behavioral Health Clinic federal demonstration and the Integrated Community Wellness Centers program. Section V, 2019 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2019 (MY 2018) EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2019), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

Supplemental Materials

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

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

I: Validation of Performance Improvement Projects

In accordance with current BBA regulations, IPRO validates at least one performance improvement project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, Primary Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. The Primary Contractors and MCOs are required to implement improvement actions and to conduct follow-up, including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action.

Background

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

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

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

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

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

Additionally, OMHSAS identified the following core PMs for the SPEDTAR PIP:

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

3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary MH diagnosis, as defined by the PA-specific FUH measure, occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.
4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[3] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe Alcohol Use Disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

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

This PIP project will extend from January 2021 through December 2023, with initial PIP proposals submitted in 2020 and a final report due in September 2024. Final baseline results will be run for the performance indicators in Summer 2021 and PIP interventions recalibrated as needed.

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

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

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

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

Validation Methodology

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[4] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 8 review elements listed below:

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

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

II: Validation of Performance Measures

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

Follow-Up After Hospitalization for Mental Illness

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing county, Primary Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

Measurement year (MY) 2002 was the first year follow-up rates were reported. Quality Indicator (QI) 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the HC BH Program that could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits. Each year, the QI 1 and QI 2 specifications are aligned with the HEDIS Follow-Up After Mental Health Hospitalization measure. The PA-specific codes that are not included in the HEDIS measure are also reviewed for accuracy on an annual basis.

Typically, HEDIS FUH undergoes annual updates to its specifications. Among the updates in 2019 (MY 2018), the National Committee for Quality Assurance (NCQA) added the following reporting strata for FUH, ages: 6–17, 18–64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are broken out by ages: 6–17, 18–64, and 6 and over (All Ages).

Measure Selection and Description

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

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

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

Eligible Population

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2019 study. Eligible cases were defined as those members in the HC BH program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2019;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2019, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2019. The methodology for identification of the eligible

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

HEDIS Follow-Up Indicators

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

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

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

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

PA-Specific Follow-Up Indicators

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

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

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

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

Quality Indicator Significance

Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2018, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year while an estimated 11.4 million adults in the nation had serious mental illness in the past year, which corresponds to 4.6% of all U.S. adults.[5] Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns, reduced use of preventive services, and substandard medical care that they receive.[6] Roughly one-third of adults with SMI in any given year did not receive any mental health services, showing a disparity among those with serious mental illness (SMI).[7] Further research suggests that more than half of those with SMI did not receive services because they could not afford the cost of care.[8] Cost of care broken down as follows: 60.8% of patients' related expenses were attributed to loss of earnings, 31.5% were attributed to healthcare expenses, while 7.7% were attributed to payments for disability benefits.[9] For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcome and to prevent long-term deterioration in people with severe and persistent mental illness.[10] As noted in *The State of Health Care Quality Report,*[11] appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses and the likelihood of recurrence. An outpatient visit within at least 30 days (ideally, 7 days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments.[12] With the expansion of

evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services.[13] One way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact.[14]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of behavioral health care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[15] Research has demonstrated that patients who do not have an outpatient appointment after discharge were more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment.[16] Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow up with outpatient care.[17]

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[18] Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or substance use disorder (SUD).[19] Measuring appropriate care transitions for members with mental illness therefore carries wider implications for the OMHSAS quality area related to SUD prevalence and outcomes.

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS and results are reviewed for potential trends each year. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

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

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2019 (MY 2018), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a 3-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass® published percentiles for 7-day and 30-day FUH. This change in 2019 also coincided with a more proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2018 results. These MY 2018 results were reported in the 2019 BBA report.

HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH-MCO for an RCA and QIP. This process is further discussed in **Section V**.

Although not part of this report, OMHSAS sponsored in 2019 the rollout of an IPRO-hosted Tableau® server reporting platform which allows users, including BH MCOs and Primary Contractors, to interactively query data and produce reports on PMs. These reports include statistical or non-statistical summaries and comparisons of rates by various

stratifications, including by demographics, such as race and ethnicity, as well as by participation status in the Medicaid Expansion program (Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2019). This interactive reporting provides an important tool for BH MCOs and their HC Oversight Entities to set performance goals as well as monitor progress toward those goals.

Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HC Aggregate (Statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the Statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2018 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *z* statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

$N1$ = Current year (MY 2019) numerator,
$N2$ = Prior year (MY 2018) numerator,
$D1$ = Current year (MY 2019) denominator, and
$D2$ = Prior year (MY 2018) denominator.

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

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

Where:

$p1$ = Current year (MY 2019) quality indicator rate, and
$p2$ = Prior year (MY 2018) quality indicator rate.

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

$$H_0: p1 = p2$$

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

Limitations

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

Findings

BH-MCO and Primary Contractor Results

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

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

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

I: HEDIS Follow-up Indicators

(a) Age Group: 18–64 Years Old

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

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

MY 2019							MY 2019 Rate Comparison to MY 2018	
				95% CI		MY 2018 %		
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD
QI1 – HEDIS 7-Day Follow-Up (18–64 Years)								
HC Statewide	10,935	30,472	**35.9%**	35.3%	36.4%	35.5%	0.4	NO
PerformCare	1,022	3,007	**34.0%**	32.3%	35.7%	38.1%	-4.1	YES
Bedford-Somerset	35	93	**37.6%**	N/A	N/A	39.8%	-2.2	N/A
Capital Area BH	885	2,678	**33.0%**	31.2%	34.8%	37.4%	-4.4	YES
Franklin-Fulton	102	236	**43.2%**	36.7%	49.8%	44.1%	-0.9	NO
QI2 – HEDIS 30-Day Follow-Up (18–64 Years)								
HC BH Statewide	16,997	30,472	**55.8%**	55.2%	56.3%	56.0%	-0.3	NO
PerformCare	1,646	3,007	**54.7%**	52.9%	56.5%	60.6%	-5.8	YES
Bedford-Somerset	54	93	**58.1%**	N/A	N/A	66.5%	-8.4	N/A
Capital Area BH	1,424	2,678	**53.2%**	51.3%	55.1%	59.4%	-6.2	YES
Franklin-Fulton	168	236	**71.2%**	65.2%	77.2%	68.1%	3.1	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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; N/A: Confidence intervals were not calculated if denominators of rates contained less than 100 members.

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

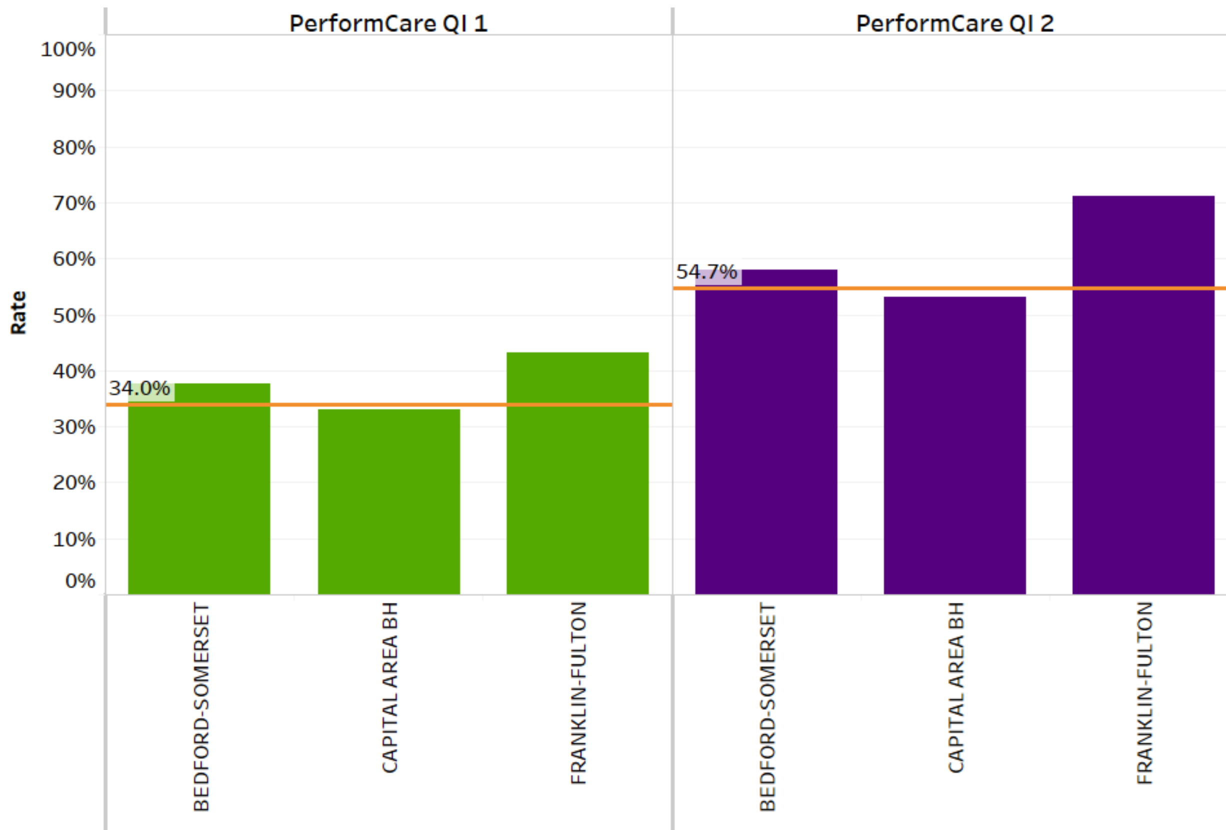

Figure 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

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

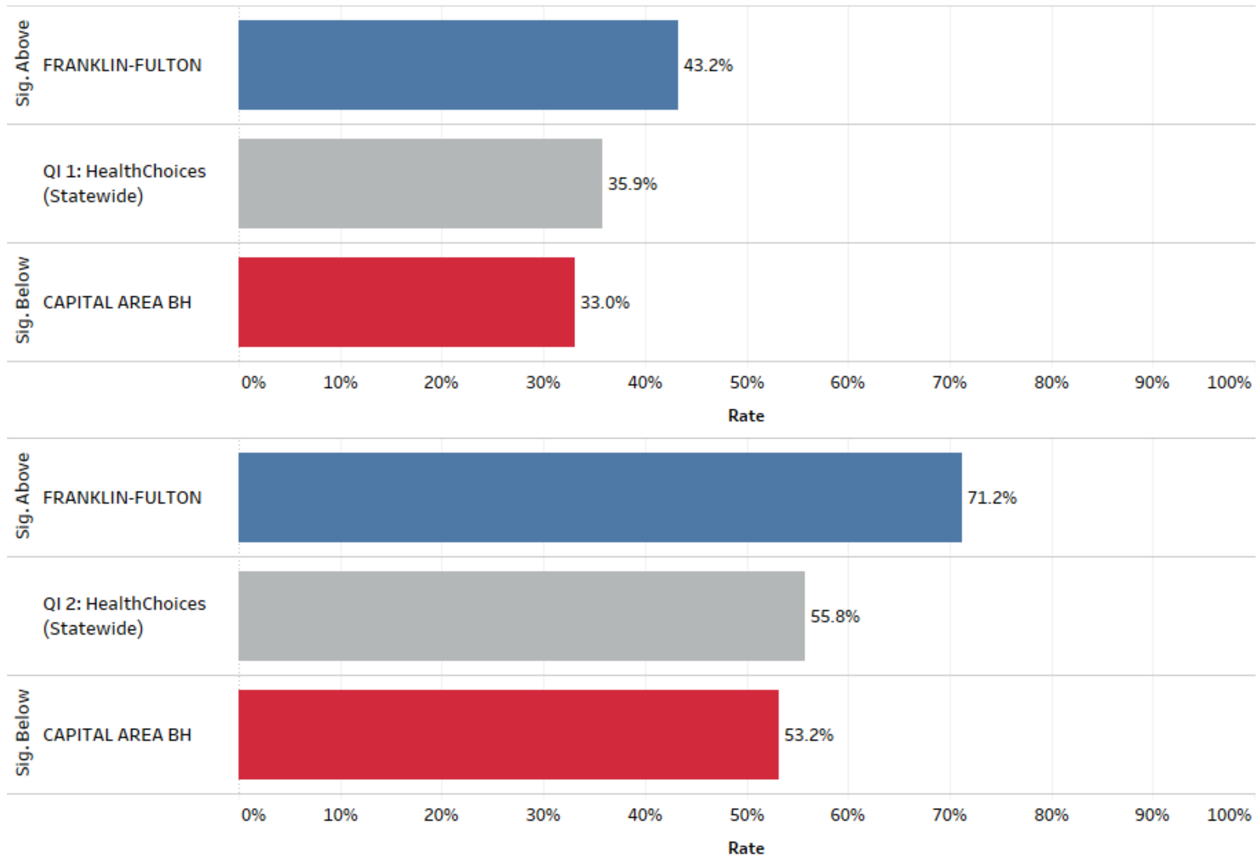

Figure 2.2: PerformCare Contractor MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years) that are Statistically Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years).

(b) Overall Population: 6+ Years Old

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

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

	MY 2019					MY 2018 %	MY 2019 Rate Comparison		
				95% CI			To MY 2018		To HEDIS 2019
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	Percentiles
QI 1 - HEDIS 7-Day Follow-Up (All Ages)									
HC BH (Statewide)	15,843	39,823	**39.8%**	39.3%	40.3%	39.4%	0.4	NO	Below 75th percentile, above 50th percentile
PerformCare	1,574	3,964	**39.7%**	38.2%	41.2%	43.8%	-4.1	YES	Below 75th percentile, above 50th percentile
Bedford-Somerset	53	124	**42.7%**	33.6%	51.9%	44.4%	-1.7	NO	Below 75th percentile, above 50th percentile
Capital Area BH	1,364	3,528	**38.7%**	37.0%	40.3%	43.4%	-4.7	YES	Below 75th percentile, above 50th percentile
Franklin-Fulton	157	312	**50.3%**	44.6%	56.0%	48.4%	1.9	NO	At or above 75th percentile
QI 2 - HEDIS 30-Day Follow-Up (All Ages)									
HC BH (Statewide)	24,029	39,823	**60.3%**	59.9%	60.8%	60.2%	0.2	NO	Below 75th percentile, above 50th percentile
PerformCare	2,406	3,964	**60.7%**	59.2%	62.2%	65.9%	-5.2	YES	Below 75th percentile, above 50th percentile
Bedford-Somerset	79	124	**63.7%**	54.8%	72.6%	70.7%	-7.0	NO	Below 75th percentile, above 50th percentile
Capital Area BH	2,093	3,528	**59.3%**	57.7%	61.0%	65.0%	-5.6	YES	Below 75th percentile, above 50th percentile
Franklin-Fulton	234	312	**75.0%**	70.0%	80.0%	71.5%	3.5	NO	At or above 75th percentile

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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.

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

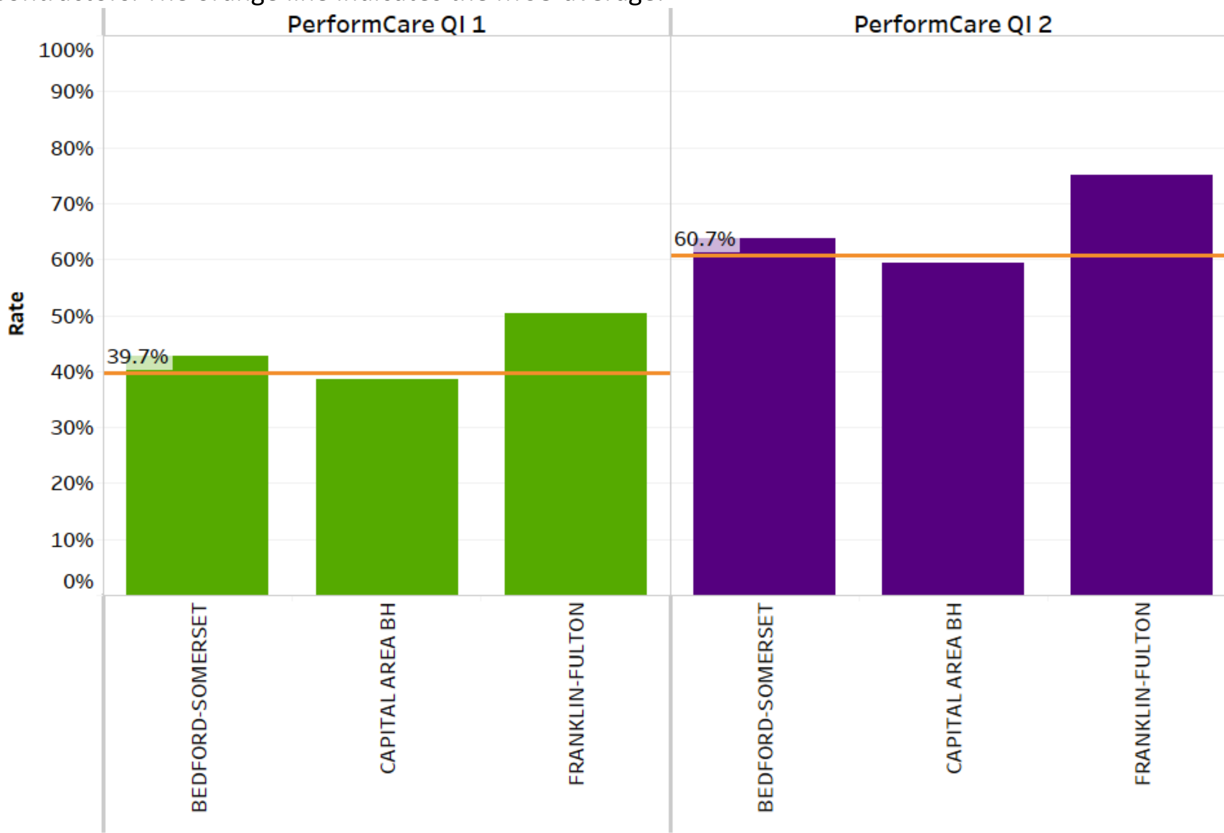

Figure 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

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

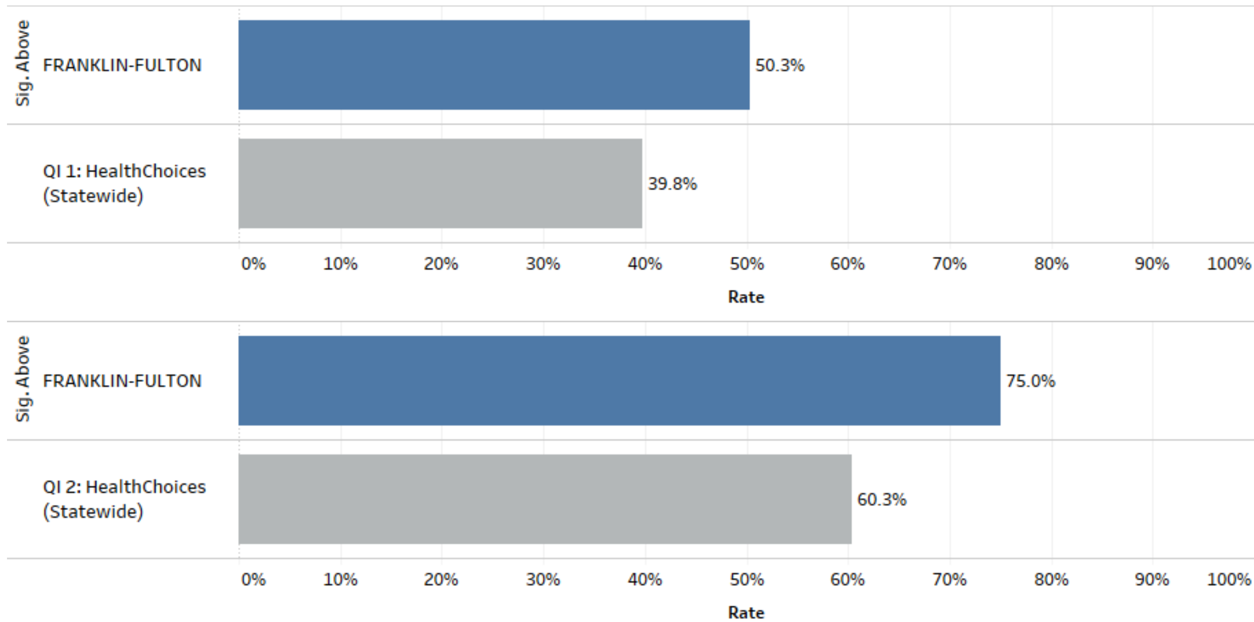

Figure 2.4: PerformCare Contractor MY 2019 HEDIS FUH Follow-Up Rates (All Ages) that are Statistically Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (All Ages).

(c) Age Group: 6–17 Years Old

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

Table 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-up Indicators (6–17 Years)

	MY 2019						MY 2019 Rate Comparison To MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	MY 2018 %	PPD	SSD
QI 1 - HEDIS 7-Day Follow-Up (6-17 Years)								
HC BH (Statewide)	4,750	8,573	**55.4%**	54.3%	56.5%	55.7%	-0.3	NO
PerformCare	536	901	**59.5%**	56.2%	62.8%	61.8%	-2.3	NO
Bedford-Somerset	18	28	**64.3%**	N/A	N/A	58.9%	5.4	N/A
Capital Area BH	465	803	**57.9%**	54.4%	61.4%	62.2%	-4.3	NO
Franklin-Fulton	53	70	**75.7%**	N/A	N/A	60.3%	15.4	N/A
QI 2 - HEDIS 30-Day Follow-Up (6-17 Years)								
HC BH (Statewide)	6,756	8,573	**78.8%**	77.9%	79.7%	77.7%	1.1	NO
PerformCare	737	901	**81.8%**	79.2%	84.4%	82.2%	-0.4	NO
Bedford-Somerset	25	28	**89.3%**	N/A	N/A	84.9%	4.4	N/A
Capital Area BH	651	803	**81.1%**	78.3%	83.8%	82.0%	-0.9	NO
Franklin-Fulton	61	70	**87.1%**	N/A	N/A	80.9%	6.3	N/A

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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; N/A: Confidence intervals were not calculated if denominators of rates contained less than 100 members.

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

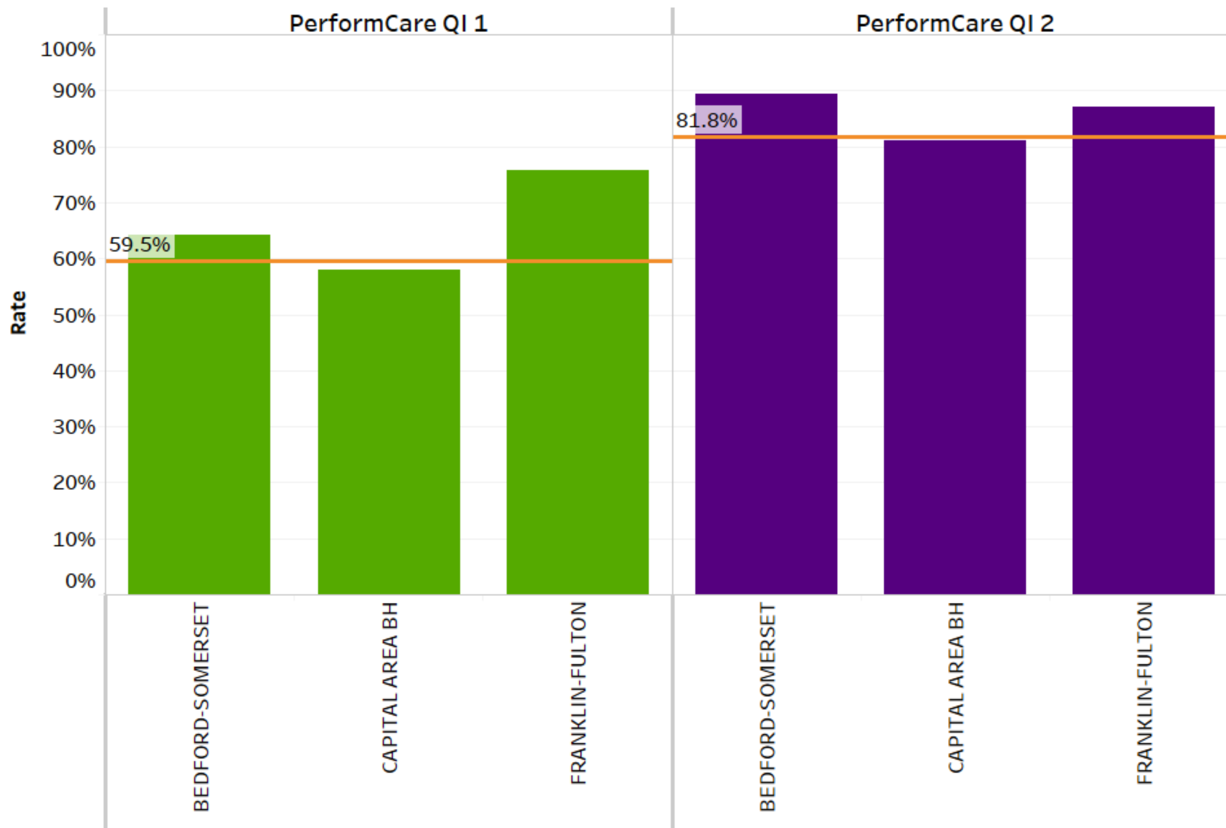

Figure 2.5: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

Figure 2.6 shows the HC BH (Statewide) rates for this age cohort. No individual Primary Contractor rates were significantly higher (blue) or lower (red) than the statewide rates.

Figure 2.6: None of the PerformCare Contractor MY 2019 HEDIS FUH Follow-up Rates (6–17 Years) are Statistically Significantly Different than HealthChoices (Statewide) MY 2019 HEDIS FUH Follow-up Rates (6–17 Years).

II: PA-Specific Follow-Up Indicators

(a) Overall Population: 6+ Years Old

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

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

	MY 2019					MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-Up (All Ages)								
HC BH (Statewide)	21,098	39,900	**52.9%**	52.4%	53.4%	53.1%	-0.2	NO
PerformCare	2,021	3,964	**51.0%**	49.4%	52.6%	57.1%	-6.1	YES
Bedford-Somerset	63	124	**50.8%**	41.6%	60.0%	55.2%	-4.4	NO
Capital Area BH	1,763	3,528	**50.0%**	48.3%	51.6%	57.0%	-7.0	YES
Franklin-Fulton	195	312	**62.5%**	57.0%	68.0%	59.3%	3.2	NO
QI B – PA-Specific 30-Day Follow-Up (All Ages)								
HC BH (Statewide)	27,741	39,900	**69.5%**	69.1%	70.0%	69.6%	-0.0	NO
PerformCare	2,762	3,964	**69.7%**	68.2%	71.1%	74.9%	-5.3	YES
Bedford-Somerset	89	124	**71.8%**	63.4%	80.1%	78.9%	-7.1	NO
Capital Area BH	2,423	3,528	**68.7%**	67.1%	70.2%	74.4%	-5.7	YES
Franklin-Fulton	250	312	**80.1%**	75.5%	84.7%	77.2%	2.9	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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.

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

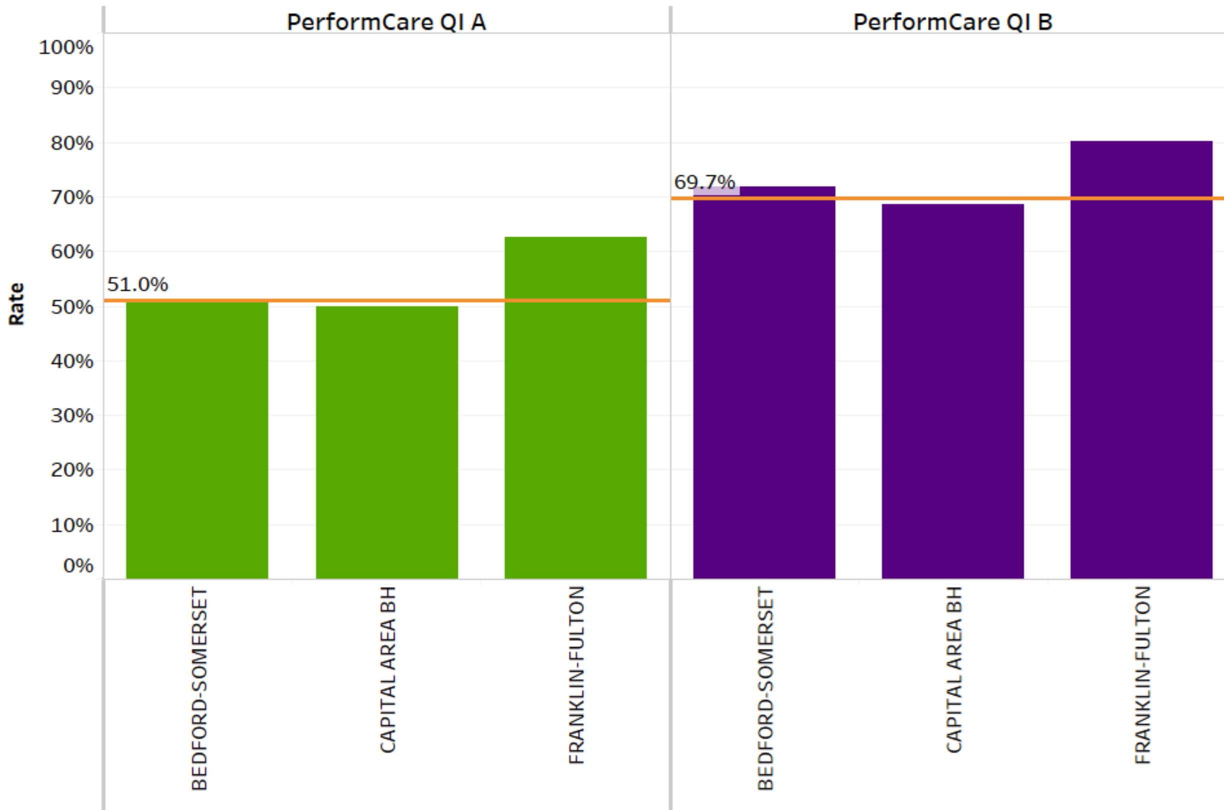

Figure 2.7: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

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

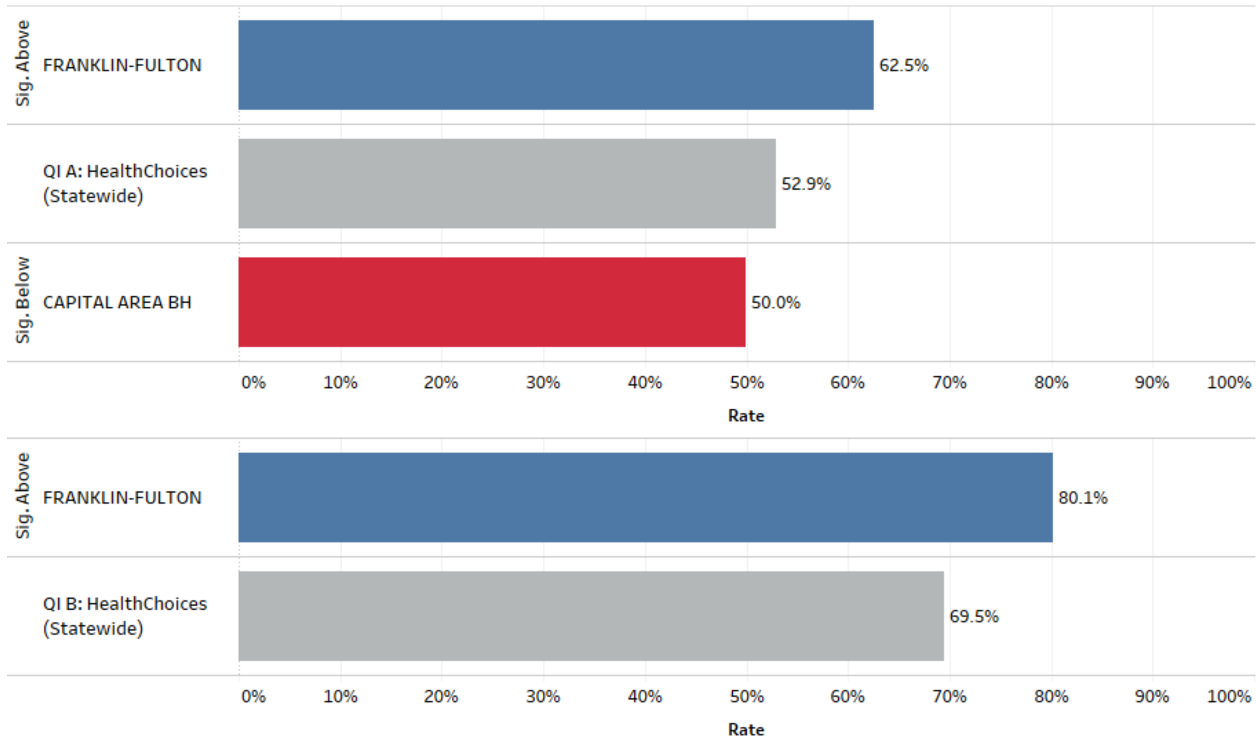

Figure 2.8: PerformCare Contractor MY 2019 PA-Specific FUH Follow-Up Rates (All Ages) that are Statistically Significantly Different than HC BH (Statewide) MY 2019 PA-Specific FUH Follow-Up Rates (All Ages).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS 2019 specifications, including revision of the denominator to include members with a principal diagnosis of intentional self-harm. That said, efforts should continue to be made to improve Follow-Up After Hospitalization for Mental Illness performance, particularly for those BH-MCOs that performed below the HC BH Statewide rate. Following are recommendations that are informed by the MY 2019 review:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2019, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health care follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable Primary Contractor exceptions, FUH rates have, for the most part decreased for the BH-MCO, in several instances significantly, and overall 7- and 30-day follow-up rates for the MCO remain below the HEDIS Quality Compass 75th percentile. As previously noted, although not enumerated in this report, further stratified comparisons such Medicaid Expansion versus non-Medicaid Expansion, were carried out in a separate 2019 (MY 2019) FUH "Rates Report" produced by the EQRO and made available to BH MCOs in an interactive Tableau workbook. BH-MCOs and Primary Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For example, it is important for BH-MCOs and Primary Contractors to analyze performance rates by racial and ethnic categories and to target the populations where racial and ethnic disparities may exist. The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance. The aforementioned 2020 (MY 2019) FUH Rates Report is one source BH MCOs can use to investigate potential health disparities in FUH.
- BH-MCOs and Primary Contractors are encouraged to review the 2020 (MY 2019) FUH Rates Report in conjunction with the corresponding 2020 (MY 2019) inpatient psychiatric readmission Rates (REA) Report. 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.
- CCBH turned in 7-day follow-up rates that met or exceeded the HEDIS 2019 75th percentile. Other BH-MCOs could benefit from drawing lessons or at least general insights from their successes.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the PM for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and remeasurement of the PM for validation soon thereafter for MY 2007, and then for MY 2008. Remeasurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2019 study conducted in 2019 was the 11th remeasurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute

facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2019. This measure continued to be of interest to OMHSAS for the purposes of comparing Primary Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined behavioral health services provided to members participating in the HC BH Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. In order to identify the administrative numerator-positives, the date-of-service, and diagnosis/procedure code criteria were outlined, as well as were other specifications as needed. This measure's calculation was based on administrative data only.

This PM assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were followed by an inpatient acute psychiatric care readmission within 30 days of the previous discharge.

Eligible Population

The entire eligible population was used for all 67 counties and 25 Primary Contractors participating in the MY 2019 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2019;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event; and
- The claim was clearly identified as a discharge.

The numerator comprised members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge.

Methodology

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

Performance Goals

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

Findings

BH-MCO and Primary Contractor Results

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2019 to MY 2018 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the *Z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the percentage point difference (PPD) between the rates.

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

Lastly, aggregate rates were compared to the OMHSAS-designated PM goal of 10.0%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2019 REA Readmission Indicators

Measure	MY 2019 (N)	MY 2019 (D)	MY 2019 %	95% CI Lower	95% CI Upper	Goal Met? [1]	MY 2018 %	MY 2019 Rate Comparison to MY 2018 PPD	MY 2019 Rate Comparison to MY 2018 SSD
Inpatient Readmission									
HC BH (Statewide)	6,803	50,310	**13.5%**	13.2%	13.8%	NO	13.7%	-0.2	NO
PerformCare	632	4,814	**13.1%**	12.2%	14.1%	NO	13.5%	-0.3	NO
Bedford-Somerset	15	145	**10.3%**	5.0%	15.6%	NO	8.8%	1.5	NO
Capital Area BH	572	4,287	**13.3%**	12.3%	14.4%	NO	13.7%	-0.3	NO
Franklin-Fulton	45	382	**11.8%**	8.4%	15.1%	YES	14.9%	-3.2	NO

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

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 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.

Figure 2.9 is a graphical representation of the MY 2019 readmission rates for PerformCare Primary Contractors compared to the OMHSAS performance goal of 10.0%. The orange line indicates the MCO average.

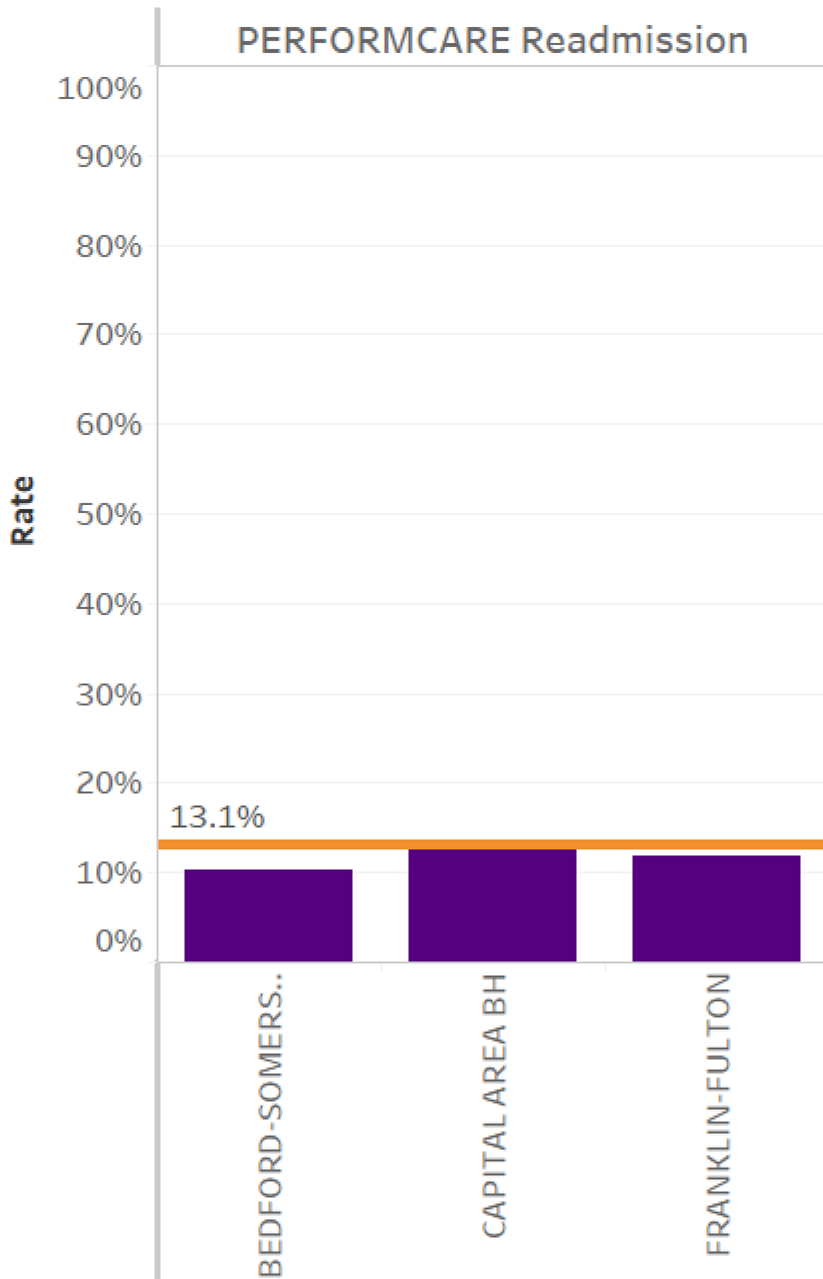

Figure 2.9: MY 2019 REA Readmission Rates for PerformCare Primary Contractors.

Figure 2.10 shows the HealthChoices BH (Statewide) readmission rate. No individual PerformCare Primary Contractors performed statistically significantly higher (red) or lower (blue) than the HC BH Statewide rate.

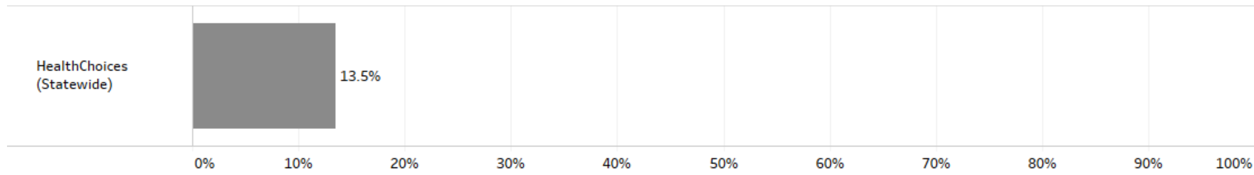

Figure 2.10: None of the PerformCare Contractor MY 2019 REA Readmission Rates (All Ages) are Statistically Significantly Different than HC BH (Statewide) MY 2019 REA Readmission Rates (All Ages).

Conclusion and Recommendations

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

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

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

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2019 to promote continuous quality improvement with regard to mental health discharges that result in a readmission. The information contained within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. In 2018, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. BH-MCOs are expected to sustain meaningful improvement in BH readmission rates going forward as a result of the PIP. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.
- The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate 2020 (MY 2019) REA "Rates Report" produced by the EQRO which is being made available to BH MCOs in an interactive Tableau workbook.
- BH-MCOs and Primary Contractors are encouraged to review the 2020 (MY 2019) REA Rates Report in conjunction with the aforementioned 2020 (MY 2019) FUH Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

III: Compliance with Medicaid Managed Care Regulations

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

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

Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties formed an HC Oversight Entity called Capital Area Behavioral Health Collaborative (CABHC). The Tuscarora Managed Care Alliance oversees the HC BH program for Franklin and Fulton Counties. 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 HealthChoices Primary Contractor(s), and the county(ies) encompassed by each Primary Contractor.

Table 3.1: HealthChoices Oversight Entities, Primary Contractors and Counties

<table>
<tr><th>HC Oversight Entity</th><th>Primary Contractor</th><th>County</th></tr>
<tr><td rowspan="5">Capital Area Behavioral Health Collaborative (CABHC)</td><td rowspan="5">Capital Area Behavioral Health Collaborative (CABHC)</td><td>Cumberland County</td></tr>
<tr><td>Dauphin County</td></tr>
<tr><td>Lancaster County</td></tr>
<tr><td>Lebanon County</td></tr>
<tr><td>Perry County</td></tr>
<tr><td rowspan="2">Tuscarora Managed Care Alliance</td><td rowspan="2">Tuscarora Managed Care Alliance
Otherwise known as Franklin-Fulton for review</td><td>Franklin County</td></tr>
<tr><td>Fulton County</td></tr>
</table>

HC: HealthChoices; BH: behavioral health; CABHC: Capital Area Behavioral Health Collaborative

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of PerformCare by OMHSAS monitoring staff within the past 3 review years (RYs 2019, 2018, and 2017). These evaluations are performed at the BH-MCO and HC Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for 2020. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HC BH Program contract are documented in the RAI. If the Readiness Review occurred within the 3-year time frame under consideration, the RAI was provided to IPRO. For those HC Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current 3-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HC BH Program's PS&R are also used.

Data Sources

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

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

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[20] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included updates to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in 42 C.F.R. 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. In addition, findings for RY 2019 are presented here under the new rubric of the three "CMS sections": Standards, including enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up was correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating 3-year schedule for all five BH-MCOs. This may, in turn, change the category tally of standards from one reporting year to the next. In 2019 (RY 2018), two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). ID numbers for some existing substandard also changed. For this report, in order to distinguish substandards, a parenthetical notation "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its 3-year review (in RY 2020).

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The RY 2019 crosswalks of PEPS Substandards to pertinent BBA regulations and to pertinent OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the HC Oversight Entities and their subcontracted BH-MCOs occurs over a 3-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The 3-year period is alternatively referred to as the Active Review period. The PEPS Substandards from RY 2019, RY 2018, and RY 2017 provided the information necessary for the 2019 assessment. Those triennial standards not reviewed through the PEPS system in RY 2019 were evaluated on their performance based on RY 2018 and/or RY 2017 determinations, or other supporting documentation, if necessary. For those HC Oversight Entities that completed their Readiness Reviews within the three-year time frame under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

For PerformCare, a total of 69 unique substandards were applicable for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2019, 2018, and 2017). In addition, 16 OMHSAS-specific Substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS Substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple

substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Substandards that are not required as part of BBA regulations but are reviewed within the 3-year cycle to evaluate the BH-MCO and the associated HC Oversight Entity against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for PerformCare

Table 3.2 tallies the PEPs Substandard reviews used to evaluate the HC Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2017–2019). Substandard counts under RY 2019 comprised annual and triennial substandards. Substandard counts under RYs 2018 and 2017 comprised only triennial substandards. By definition, only the last review of annual substandards is counted in the 3-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 91, differs from the unique count of substandards that came under active review (69).

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

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	2019	2018	2017
CMS EQR Protocol 3 "sections": Standards, including enrollee rights and protections					
Assurances of adequate capacity and services	5		5		
Availability of Services	24		16	6	2
Confidentiality	1		1		
Coordination and continuity of care	2				2
Coverage and authorization of services	4		2		2
Health information systems	1		1		
Practice guidelines	6		4		2
Provider selection	3			3	
Subcontractual relationships and delegation	8		8		
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program	26		26		
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems	11		2		0
Total	**91**		**65**	**9**	**17**

[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, 91, differs from the unique count of substandards that came under active review (69).
BBA: Balanced Budget Act; PEPS: Program Evaluation Performance Summary; NR: substandards not reviewed.

Determination of Compliance

To evaluate HC Oversight Entity/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision (category) and evaluated the Primary Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of "met," "partially met," or "not met" in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HC Oversight Entity/BH-MCO, it was assigned a value of "not determined." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the HC Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HC Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HC Oversight Entity/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. A value of null was assigned to a provision when none of the existing PEPS Substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results within a given category were aggregated to arrive at a

summary compliance status for the category. For example, compliance findings relating to provider network mix and capacity are summarized under Assurances of adequate capacity and services, 42 C.F.R. § 438.207.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[21] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) program, and Grievance System.

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

Findings

Sixty-nine (69) unique PEPS Substandards were used to evaluate PerformCare and its Oversight Entities compliance with BBA regulations in RY 2019.

Standards, including Enrollee Rights and Protections

The general purpose of the regulations included in this section is to ensure that each Primary Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the Primary Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. **Table 3.3** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.3: Compliance with Standards, including Enrollee Rights and Protections

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Assurances of adequate capacity and services 42 C.F.R. § 438.207	5	Compliant	All PerformCare 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	Partial	All PerformCare 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, 93.1, 93.2, 93.3, 93.4		28.1, 28.2
Confidentiality 42 C.F.R. § 438.224	1	Compliant	All PerformCare Primary Contractors	120.1		
Coordination and continuity of care 42 C.F.R. § 438.208	2	Compliant	All PerformCare Primary Contractors	28.1, 28.2		
Coverage and authorization of services 42 C.F.R. Parts §	4	Partial	All PerformCare Primary Contractors		72.2	28.1, 28.2, 72.1

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114						
Health information systems 42 C.F.R. § 438.242	1	Compliant	All PerformCare Primary Contractors	120.1		
Practice guidelines 42 C.F.R. § 438.236	6	Partial	All PerformCare Primary Contractors	93.1, 93.2, 93.3, 93.4		28.1, 28.2
Provider selection 42 C.F.R. § 438.214	3	Compliant	All PerformCare Primary Contractors	10.1, 10.2, 10.3		
Subcontractual relationships and delegation 42 C.F.R. § 438.230	8	Compliant	All PerformCare 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; CABHC: Capital Area Behavioral Health Collaborative

There are nine (9) categories within Standards, including Enrollee Rights and Protections. PerformCare was compliant with 6 categories and partially compliant with 3 categories.

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, including Enrollee Rights and Protections. PerformCare and its Primary Contractors were reviewed on all 54 substandards. Primary Contractors with PerformCare were compliant in 46 instances, partially compliant in one instance, and non-compliant in seven 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.

Availability of Services

PerformCare was partially compliant with Availability of Services due to non-compliance with two substandards within PEPS Standards 28 (RY 2017).

PerformCare non-was compliant with Substandard 1 and 2 within Standard 28 (RY 2017).

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

> **Substandard 1:** Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
>
> **Substandard 2:** The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.

Coverage and Authorization of Services

PerformCare was partially compliant with Practice Guidelines due to partial compliance with one substandard within PEPS Standard 72 (RY 2019), non-compliance with one substandard within PEPS Standard 72 (RY 2019), and non-compliance with two substandards within PEPS Standards 28 (RY 2017).

PerformCare was non-compliant with Substandard 1 and 2 within Standard 28 (RY 2017).

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

PerfomCare was partially compliant with Substandard 2 within Standard 72 (RY 2019) and non-compliant with Substandard 1 within Standard 72 (RY 2019).

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

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

Substandard 2: The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

Practice Guidelines

PerformCare was partially compliant with Practice Guidelines due to non-compliance with two substandards within PEPS Standards 28 (RY 2017).

PerformCare was non-compliant with Substandard 1 and 2 within Standard 28 (RY 2017).

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

Quality Assessment and Performance Improvement (QAPI) Program

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid Managed Care program, the HealthChoices 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 PerformCare 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, 93.3, 93.4, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4		

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

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for all Primary Contractors associated with PerformCare. Primary Contractors were compliant with all 26 substandards.

Grievance System

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the Primary Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 3.5** presents the findings by categories consistent with the regulations.

Table 3.5: Compliance with Grievance System

Federal Category and CFR Reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Grievance and appeal systems 42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	11	Partial	All PerformCare Primary Contractors	71.1	68.3, 68.4, 68.9, 71.3, 71.4, 71.9, 72.2	68.1, 68.4 (RY 2016, 2017), 72.1

MCO: managed care organization; CFR: Code of Federal Regulations; CABHC: Capital Area Behavioral Health Collaborative.

For this review, 11 substandards were crosswalked to Grievance System. All 11 substandards were reviewed for all Primary Contractors associated with PerformCare. PerformCare and its Primary Contractors were compliant with 1 substandard, partially compliant with 7 substandards, and non-compliant with 3 substandards.

Grievance and Appeal Systems

PerformCare was partially compliant with Grievance and Appeal Systems due to partial compliance with substandards of PEPS Standards 68 (RY 2017), 71 (RY 2017), and 72 (RY 2019) and non-compliance with substandards of PEPS Standards 68 (RY 2017) and 72 (RY 2019).

PerformCare was partially compliant with Substandard 3, 4, and 9 within Standard 68 (2017) and non-compliant with Substandards 1 and 4 (RY 2016, 2017) within Standard 68 (2017).

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

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

Substandard 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.

PerformCare was partially compliant with Substandards 3, 4, and 9 within Standard 71 (RY 2017).

Standard 71: Grievance and the Department's fair hearing rights and procedures are made known to EAP, 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 4: Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.

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

PerformCare was partially compliant with Substandard 2 within Standard 72 (RY 2019) and non-compliant with Substandard 1 within Standard 72 (RY 2019).

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

IV: Quality Studies

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

Certified Community Behavioral Health Clinics

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

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

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

Demonstration Year 2 Results

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

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

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

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

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

Measure	CCBHC Weighted Average	Comparison		
		State Weighted Average	National Average	Description (if National)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.6%	88.3%		
Plan All-Cause Readmissions Rate (lower is better)	15.5%	12.6%		
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	82.0%		35.0%	MIPS 2020 (eCQMs)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	82.2%		39.3%	MIPS 2020 (eCQMs)
Screening for Depression and Follow-Up Plan	44.8%		37.0%	MIPS 2020 (eCQMs)
Depression Remission at Twelve Months	7.2%		12.8%	MIPS 2020 (eCQMs)
Body Mass Index (BMI) Screening and Follow-Up Plan	52.1%		47.6%	MIPS 2020 (Claims)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	69.8%		79.1%	HEDIS 2019 Quality Compass 50th Percentile
Tobacco Use: Screening and Cessation Intervention	63.4%		60.4%	MIPS 2019 (CMS Web Interface Measures)
Unhealthy Alcohol Use: Screening and Brief Counseling	91.6%		68.4%	MIPS 2019 (Registry)

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

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

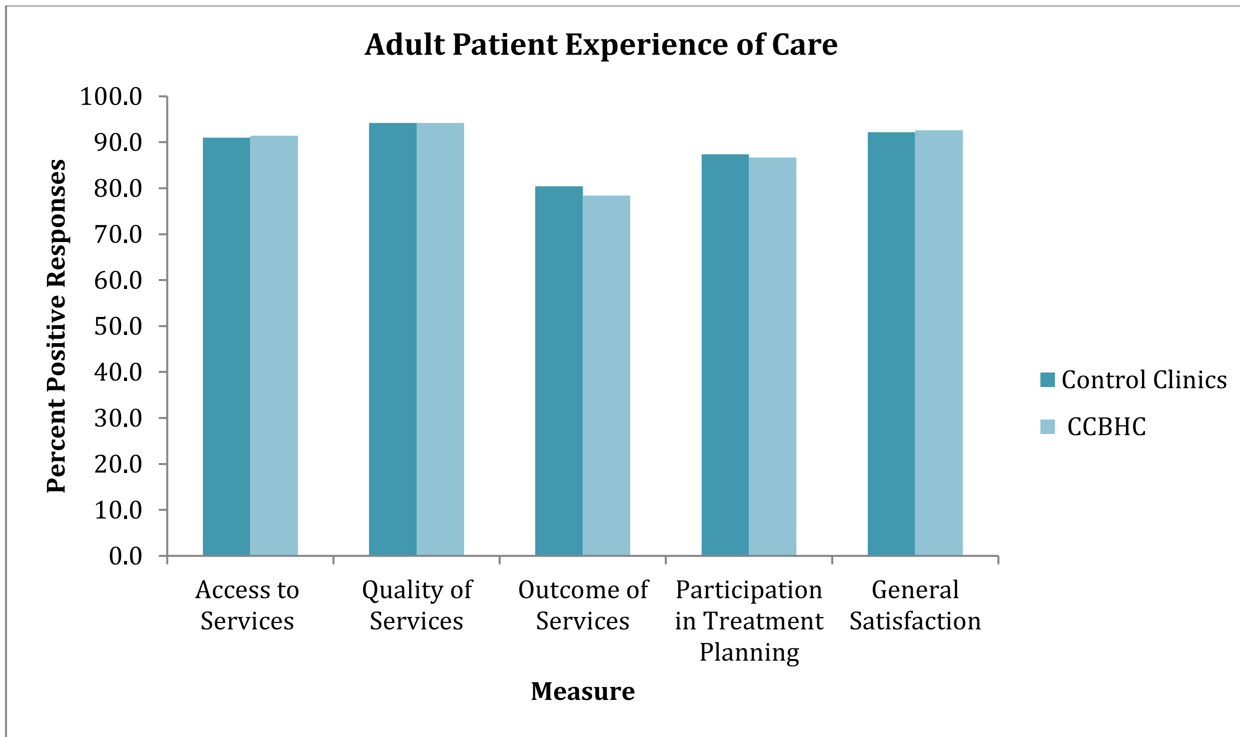

Figure 4.1: Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care.

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

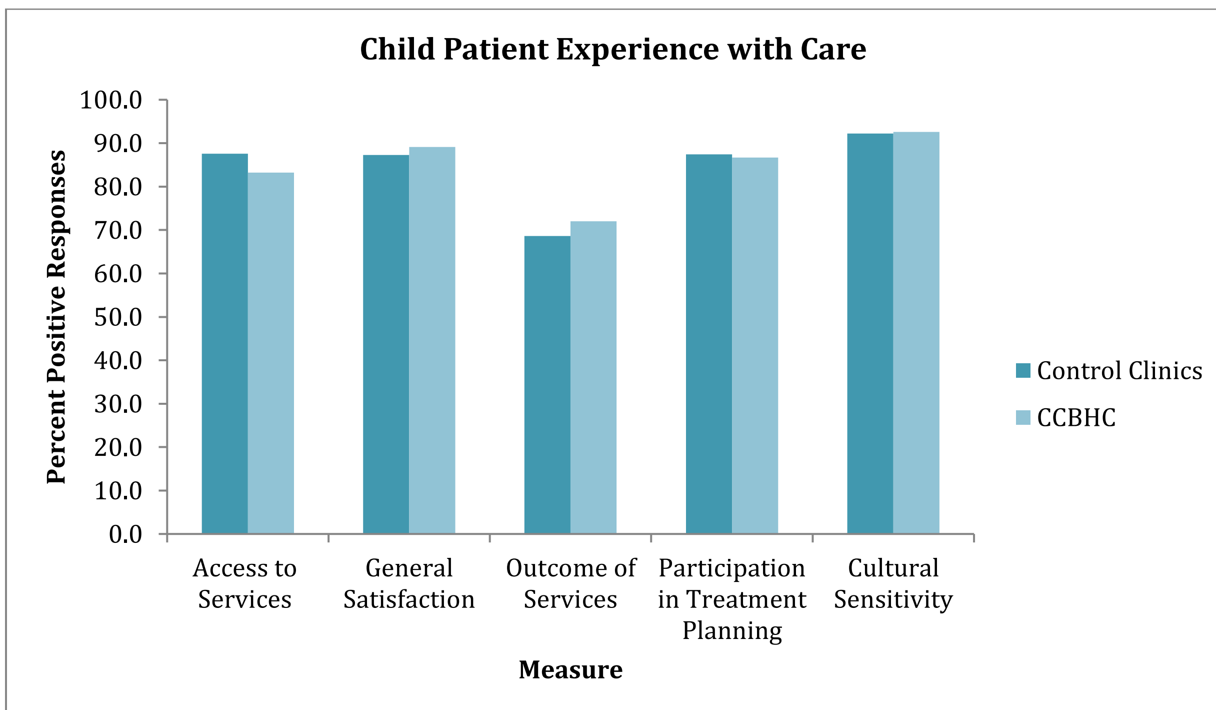

Figure 4.2: Comparison of CCBHC to Control Clinics on Child Patient Experience of Care.

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

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

Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the CCBHC Demonstration but to continue and build on the CCBHC model in a PA DHS-administered Integrated Community Wellness Centers (ICWC) program under an MMC agreement with CMS. Under this agreement, the same nine core services of the CCBHC model would be provided under PA's HealthChoices MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the original seven clinics—Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA)—were certified to participate in the new program.

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

Table 4.2: ICWC Annual and Quarterly Quality Measures

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

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

V: 2019 Opportunities for Improvement – MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH-MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2019 EQR Technical Reports and in the 2020 (MY 2019) FUH All-Ages Goal Report.

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

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

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

The documents informing the current report include the responses submitted to IPRO as of the end of 2020, as well as any additional relevant documentation provided by the BH-MCO.

The request for MCO response to the opportunities for improvement related to MY 2019 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2019 results, in January 2021. The Root Cause Analysis and Quality Improvement Plan form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed quality improvement plan to address those factors, complete with a timeline of implementation, monitoring, and reporting activities. BH-MCOs submitted their responses by March 15, 2021.

Quality Improvement Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2018, PerformCare began to address opportunities for improvement related to compliance categories within the following Subparts: C (Enrollee Rights and Protections Regulations), D (Quality Assessment and Performance Improvement), and F (Federal and State Grievance System Standards Regulations). Within Subpart C, PerformCare was partially compliant with Enrollee Rights. Within Subpart D, PerformCare was partially compliant with: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, 3) Subcontractual Relationships and Delegation, and 4) Practice Guidelines. PerformCare was non-compliant with Coordination and Continuity of Care. Within Subpart F, PerformCare was partially compliant with: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by PerformCare were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring PerformCare into compliance with the relevant Standards.

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

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

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/ None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
PerformCare 2019.01	Within Subpart C: Enrollee Rights and Protections Regulations, PerformCare was partially compliant with one out of seven categories – Enrollee Rights.	Date(s) of follow-up action(s) **PEPS Standard 60** 1. 12/31/2019 2. 06/11/2020	Describe one follow-up action. **PEPS Standard 60** *Substandard 2 Compliant and Grievance Staff are adequately trained* 1. Revised training rosters and curriculum Curriculum and Power Point attached *Substandard 3 Compliant and Grievance Policies and Procedures comply with Appendix H* 2. Revised the Complaint and Grievance Policies and Procedures to ensure compliance with Appendix H: QI-042 6-Criteria Complaint – revised 08/21/2018 and reviewed 07/11/2019 QI-043 Dissatisfaction Complaint – revised and approved 02/06/2020 QI-044 Grievance – revised 07/27/2020 and reviewed 06/11/2020 QI-045 Provider Complaint Process – revised 12/31/2019 and reviewed 01/24/2020 QI-046 Compliant and Grievance Information Distribution Policy – revised 12/19/2019 and reviewed 02/06/2020 QI-047 Complaint and Grievance Referrals Regarding Corporate Compliance Issues – revised 12/19/2019 and reviewed 02/06/2020 QI-048 Informal Complaint – effective and approved 02/06/2020
		Date(s) of future action(s) **PEPS Standard 60** 1. 12/31/2020 2. 06/30/2021	Describe one future action. **PEPS Standard 60** 1. Complete annual C&G staff training and BH-MCO staff training 2. Complete annual Policy and Procedure review and if necessary, make revisions to ensure compliance with Appendix H
		Date(s) of follow-up action(s) **PEPS Standard**	Describe one follow-up action. **PEPS Standard 108**

<table>
<tr><th>Reference Number</th><th>Opportunity for Improvement</th><th>Date(s) of Follow-Up Action(s) Taken/Planned</th><th>MCO Response</th></tr>
<tr><td colspan="2" rowspan="2">Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.</td><td>Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/ None</td><td>Address within each subpart accordingly.</td></tr>
<tr><td>Date(s) of future action(s) planned/None</td><td>Address within each subpart accordingly.</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td>108
1. 08/27/2019
2. November 2019
3. January 2020
4. 01/20/2020 to 03/06/2020
5. 04/10/2020</td><td>Substandard 8 – Annual mailed / telephonic survey results
1. 2019 Annual Member Satisfaction Survey Report submitted to Primary Contractors
2. Annual selection of Member sample:
a. Eligible Members include all Members receiving services in the previous 12 months; ratio of Members per contract; representative of both mental health and substance use services; representative of Child/Adolescent and Adult Member populations; representative of Members who have filed complaint or grievance.
b. Results and interventions were reported at the QI/UM Committee Meetings in October; PerformCare identified deficient areas and implemented appropriate actions as documented in the Annual Program Evaluation
3. Additionally, C/FST survey results were incorporated into year-end Provider Profiling reports
4. 2020 Annual Member Satisfaction Survey sent out to Members
5. Member Satisfaction Survey data provided to PerformCare</td></tr>
<tr><td>Date(s) of future action(s)
PEPS Standard 108
1. 8/24/2020
2. October to November 2020
3. January 2021
4. January to March 2021</td><td>Describe one future action.

PEPS Standard 108
1. 2020 Survey report to Primary Contractors
2. 2020 Survey results to be presented to QI/UM Committee and deficient areas identified / 2021 Survey sample selected
3. Incorporation of C/FST survey results into the year-end Provider Profiling reports.
4. Completion of 2021 Annual Member Satisfaction survey.
Annual surveys will be completed beyond 2021 and in accordance with the PEPS 108 Substandard 8</td></tr>
</table>

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/ None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
PerformCare 2019.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, PerformCare was partially compliant with four out of 10 categories and one out of 10 categories is non-compliant. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, 3) Subcontractual Relationships and Delegation, and 4) Practice Guidelines The Non-Compliant category is 1) Coordination and Continuity of Care	Date(s) of follow-up action(s) **PEPS Standard 28** 1. 01/15/2020 2. 06/30/2020 3. 08/15/18 4. 03/28/19 04/12/19	Describe one follow-up action. 1) Availability of Services (Access to Care) 2) Coordination and continuity of care 3) Coverage and Authorization of Services 4) Practice Guidelines **PEPS Standard 28** *Substandard 1 Clinical/Chart Documentation* 1. Revised CCM documentation Audit Tool and implemented internal monthly audits to ensure compliance with Substandard 1 *Substandard 2 PA Documentation* 2. Revised Psychiatrist and Psychologist Advisor documentation Audit Tool and implemented internal monthly audits to ensure compliance with Substandard 2 3. Completed Appendix AA Updates 4. Completed CCM Appendix AA and Denial Trainings
		Date(s) of future action(s) planned **PEPS Standard 28** 1. July to December 2020 2. January to December 2021	Describe one future action. **PEPS Standard 28** 1. Completion of monthly audits of CCM and PA documentation to ensure compliance with Substandard 1 and 2 2. Completion of CCM Appendix AA and Denial Trainings

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/ None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action(s) **PEPS Standard 72** 1. 12/31/2018 2. 12/31/2018 3. 02/18/2020 4. 12/11/2019 12/13/2019 02/26/2020 02/27/2020	Describe one follow-up action. 2) Coverage and Authorization of Services **PEPS Standard 72** *Substandard 1 Denial Notices time frames and language* 1. Revised Denial Notices & enhanced training to ensure compliance with Substandard 1 *Substandard 2 Denial Notices content compliance* 2. Improved content of Notices to ensure compliance with Substandard 2 3. PA Denial Trainings – Psychologists in accordance with Appendix AA 4. Psychiatrist Denial Trainings in accordance with Appendix AA
		Date(s) of future action(s) planned **PEPS Standard 72** 2020 and 2021	Describe one future action. **PEPS Standard72** 1. Complete denial letter and notice audits 2. Complete annual denial training
		Date(s) of follow-up action(s) **PEPS Standard 99** 1. 06/30/2020 2. April 2019 October 2019 April 2020 3. Monthly state reports (12)	Describe one follow-up action. 4) Sub-contractual Relationships and Delegation **PEPS Standard 99** *Substandard 2 BHMCO Reports monitoring results for Adverse Incidents* 1. Continued the use of the revised Provider Adverse Incident reporting requirements and the automated avenues to reporting. 2. Adverse Incidents (Critical Incident Reporting) presentations at the QI/UM Committee meetings. 3. PerformCare submitted Monthly Adverse Incident reports to the State, the report ran on the 2nd Saturday of the month and was submitted the following Monday, in accordance with reporting specifications and in compliance with PEPS Standard 99 substandard 2
		Date(s) of future	Describe one future action.

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		action planned/None **PEPS Standard 99** 1. July to December 2020 2. October 2020 April 2021	**PEPS Standard** 99 1. Monthly submission of adverse incident report to the State and Primary Contractors 2. QI/UM Committee report presentations; statistics and follow-up actions are addressed by QOCC and Sub-QOCC on a Provider/Member specific concern
PerformCare 2019.03	Within Subpart F: Federal and State Grievance System Standards Regulations, PerformCare was partially compliant on nine out of 10 categories The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.	Date(s) of follow-up action(s) **PEPS Standard 68** 1. 12/31/2019 2. 07/01/2019 3. July 2019 to June 2020 4. July 2019 to June 2020 5. July 2019 to June 2020	Describe one follow-up action. 1) Statutory Basis and Definitions 2) General Requirements 4) Handling of Grievances and Appeals 5) Resolution and Notification: Grievances and Appeals 6) Information to Providers and Subcontractors **PEPS Standard 68** *Substandard 1 Complaint Coordinator understanding and Substandard 4 Complaint File documentation* 1. Revised Complaint Coordinator Training implemented to ensure compliance with Substandard 1 and 4 *Substandard 3 Complaint Acknowledgement and decision letter timeliness and template usage and Standard 4 Complaint Acknowledgement and Decision Letter language and content* 2. Revised Client letter implemented ensuring 100% compliance with Appendix H Template and Substandard 3 and 4 3. Continued Complaint Reviewer education regarding the use of clear, simple language and all other requirements of Substandard 4 *Substandard 3, 4, and 9 Complaint case files include documentation of Primary Contractor / BH-MCO committee referrals* 4. Continued the use of the enhanced Jiva Assessment for Complaint cases to ensure compliance with substandard 3, 4 and 9 *Substandard 2, 3, 4, and 9* 5. Internal quarterly audits conducted for

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Substandard 2, 3, 4, and 9; audits demonstrated full compliance
		Date(s) of future action(s) planned **PEPS Standard 68** 1. 12/31/2020 2. July to December 2020 January to December 2021	Describe one future action. **PEPS Standard** 68 1. Completion of Complaint Coordinator and Reviewer training 2. Items 2 through 5 - Conduct quarterly internal audits for compliance with Substandard 3, 4, and 9
		Date(s) of follow-up action(s) **PEPS Standard 60** 3. 12/31/2019 4. 12/31/2019	Describe one follow-up action. **PEPS Standard 60** *Substandard 2 Compliant and Grievance Staff are adequately trained* 1. Substandard 2 – Revised training rosters and curriculum Curriculum and Power Point attached *Substandard 3 Compliant and Grievance Policies and Procedures comply with Appendix H* 2. Revised the Complaint and Grievance Policies and Procedures to ensure compliance with Appendix H: QI-042 6-Criteria Complaint – revised 08/21/2018 and reviewed 07/11/2019 QI-043 Dissatisfaction Complaint – revised and approved 02/06/2020 QI-044 Grievance – revised 07/27/2020 and reviewed 06/11/2020 QI-045 Provider Complaint Process – revised 12/31/2019 and reviewed 01/24/2020 QI-046 Compliant and Grievance Information Distribution Policy – revised 12/19/2019 and reviewed 02/06/2020 QI-047 Complaint and Grievance Referrals Regarding Corporate Compliance Issues – revised 12/19/2019 and reviewed 02/06/2020 QI-048 Informal Complaint – effective and

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			approved 02/06/2020
		Date(s) of future action(s) **PEPS Standard 60** 1. 12/31/2020 2. 12/31/2020	Describe one future action. **PEPS Standard 60** 1. Complete annual C&G staff training 2. Complete annual BH-MCO staff training
		Date(s) of follow-up action(s) **PEPS Standard 71** 1. 07/01/2019 2. July 2019 to June 2020 3. 07/01/2019 4. July 2019 to June 2020 5. July 2019 to June 2020	Describe one follow-up action. 1) Statutory Basis and Definitions 2) General Requirements 4) Handling of Grievances and Appeals 5) Resolution and Notification: Grievances and Appeals 6) Expedited Appeals Process 7) Information to Providers and Subcontractors 8) Continuation of Benefits 9) Effectuation of Reversed Resolutions **PEPS Standard 71** *Substandard 3 100% of Grievance Acknowledgement and Decision letters adhere to the established time lines* *Substandard 4 Grievance decision letters compliance with language requirements* 1. Revised and implemented Client letter ensuring 100% compliance with Appendix H Template and Substandard 3 and 4 2. Continued educational meetings with Psychologist and Physician Advisors regarding language requirements outlined in Substandard 3 and 4. *Substandard 3, 4 and 9 Grievance case files document Primary Contractor / HB-MCO Committee Referrals and corrective action and follow-up* 3. Revised Committee Review template implemented to ensure compliance with the substandard 3, 4 and 9 4. Continued the use of the enhanced Jiva Assessment for Grievance cases to ensure compliance with substandard 3, 4 and 9 5. Internal quarterly audits conducted for Substandard 3, 4 and 9; audits demonstrated

Reference Number	Opportunity for Improvement	Date(s) of Follow-Up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found PerformCare to be partially compliant with all three Subparts and non-compliant with one of the Subparts associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			full compliance
		Date(s) of future action(s) planned **PEPS Standard 71** July to December 2020 January to December 2021	Describe one future action. **PEPS Standard 71** Conduct quarterly internal audits for compliance with Substandard 2, 3 and 4
		Date(s) of follow-up action(s) **PEPS Standard 72** 1. 12/31/2018 2. 12/31/2018 3. 02/18/2020 4. 12/11/2019 12/13/2019 02/26/2020 02/27/2020	Describe one follow-up action. 2) Coverage and Authorization of Services **PEPS Standard 72** *Substandard 1 Denial Notices time frames and language compliance* 1. Revised Denial Notices & enhanced training to ensure compliance with Substandard 1 *Substandard 2 Denial Notices content compliance* 2. Improved content of Notices to ensure compliance with Substandard 2 3. Completed PA Denial Trainings – Psychologists in accordance with Appendix AA 4. Completed Psychiatrist Denial Trainings in accordance with Appendix AA
		Date(s) of future action(s) planned **PEPS 72** 2020 and 2021	Describe one future action. **PEPS 72** Completion of denial letter and notice audits Completion of annual denial training

Root Cause Analysis and Quality Improvement Plan

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

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

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

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

Instead, in late 2020, MY 2019 results were calculated and compared to the MY 2019 goals to determine RCA and QIP assignments, along with goals, for MY 2021. In MY 2019, PerformCare 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 5.2** presents PerformCare's submission of its RCA and QIP for the FUH All-Ages 7-day measure, and **Table 5.3** presents PerformCare's submission of its RCA and QIP for the FUH All-Ages 30-day measure. Objects embedded within the tables have been removed as exhibits but are available upon request.

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

<table>
<tr><th colspan="2">RCA for MY 2019 Underperformance</th></tr>
<tr><td><u>Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):</u>
PerformCare used a series of internal and external workgroups made up of key stakeholders including Members Certified Peer Support Specialists and Providers to identify barriers to Member follow-up with mental health outpatient appointments.
The MY 2019 validated HEDIS FUH 7-day rates and data were used to analyze the population, diagnoses, and network providers experiencing the poor follow-up rates. PerformCare also used the internal 2020 YTD (January to November) Quality Dashboards to analyze the data for CY 2020. Additional data analyze was completed using the PerformCare discharge assessment and follow-up after hospitalization (FUH) activities reports.
A comparative analysis was used to identify the drivers of the low follow-up rates and a barrier analysis was used to identify the barriers to Members completing follow-up outpatient appointments. The workgroup participants identified the top three barriers by voting on the identified barriers.
The workgroups used the top three barriers to identify interventions to address the barriers.</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 overall FUH data findings for MY 2019 and YTD 2020 data periods identified the following drivers of the low FUH rates:
1. CABHC Members
2. Adults (ages 18+)
3. The prominent diagnoses included Major Depressive Disorder, Schizophrenia / Psychosis, Bipolar disorder and Mood disorders
The findings also showed that Member FUH rates were higher when Targeted Care Management (TCM) was involved.
The top three barriers identified by the workgroups included:
1. Communication between Inpatient /consumer/outpatient
2. Lack of follow-up outpatient appointments
3. Member inability to connect with telehealth service
The interventions identified by the workgroups included:
1. Explore the implementation of Project Re-Engineered Discharge (Project RED) with two additional mental health inpatient providers
2. Develop a joint operating agreement to be used between mental health inpatient facilities and outpatient providers to ensure communications between the inpatient facilities, Members and outpatient providers and compliance with new value based purchasing requirements
3. Develop and implement ongoing communication protocol with all in network mental health inpatient providers on how to access the PerformCare Provider Directory and the various mental health outpatient provider resources
4. Develop and distribute to all in network mental health providers and mental health outpatient providers a Telehealth Tool Kit that includes:
a. An assessment tool to be used to determine a Member’s ability and capacity to participate in telehealth services
b. A protocol for addressing non-telehealth options
c. A checklist of materials required to have a Member participate in the telehealth appointment
d. A communication protocol for providers

Perform and the Primary Contractors did not complete an analysis on the racial and/or ethnic disparities. This type of analysis requires consideration of the total HealthChoices eligible population and PerformCare is in the process of defining the data model/process to fully and accurately capture the necessary data. Additionally, PerformCare anticipates that this will require a survey of the Members not currently receiving mental health services through PerformCare and a barrier analysis to determine any disparities.</td></tr>
</table>

RCA for MY 2019 Underperformance	
	The PerformCare HEDIS FUH 30-day rate goal is 50%.
List out below the factors you identified in your RCA. <u>Insert more rows as needed (</u>e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance 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) Communication between Inpatient /consumer/outpatient	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members report showing up for follow-up appointments and being told there is no appointment scheduled, Members report having appointments cancelled and/or rescheduled prior to arriving for appointment, and incomplete communication of open access and walk-in opportunities. These factors cause follow-up appointments outside the 7-day measure. Critical
	Current and expected actionability: Improved communication of follow-up appointments resulting in Member attending the appointment.
People (2) Lack of follow-up outpatient appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members and Providers report a lack of appointments when attempting to schedule appointments within 7-days. First time appointments often require an in-person appointment and COVID restrictions limit the number of in-person appointments versus telehealth appointments. If appointments are not available, the 7-day follow-up cannot be met. Critical
	Current and expected actionability: Increased availability of in-person appointments and improvement in open access and walk-in appointments
People (3) Member inability to connect with telehealth service	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical
	Current and expected actionability: Improvement in Member engagement in telehealth services.
Providers (1) Communication between inpatient provider /consumer/outpatient provider	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members report showing up for follow-up appointments and being told there is no appointment scheduled, Members report having appointments cancelled and/or rescheduled prior to arriving for appointment, and incomplete communication of open access and walk-in opportunities. These factors cause follow-up appointments outside the 7-day measure. Critical
	Current and expected actionability: Improved communication of follow-up appointments resulting in

RCA for MY 2019 Underperformance	
	Member attending the appointment.
Providers (2) Lack of follow-up outpatient appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members and Providers report a lack of appointments when attempting to schedule appointments within 7-days. First time appointments often require an in-person appointment and COVID restrictions limit the number of in-person appointments versus telehealth appointments. If appointments are not available, the 7-day follow-up cannot be met. Critical
	Current and expected actionability: Increased availability of in-person appointments and improvement in open access and walk-in appointments
Providers (3) Member inability to connect with telehealth service	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical
	Current and expected actionability: Improvement in Member engagement in telehealth services.
Policies / Procedures(1) Communication between Inpatient /consumer/outpatient	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members report showing up for follow-up appointments and being told there is no appointment scheduled, Members report having appointments cancelled and/or rescheduled prior to arriving for appointment, and incomplete communication of open access and walk-in opportunities. These factors cause follow-up appointments outside the 7-day measure. Critical
	Current and expected actionability: Improved communication of follow-up appointments resulting in Member attending the appointment.
Policies / Procedures (2) Member inability to connect with telehealth service	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical
	Current and expected actionability: Improvement in Member engagement in telehealth services.
Provisions (1) *Member inability to connect with telehealth service*	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical

RCA for MY 2019 Underperformance	
	Current and expected actionability: Improvement in Member engagement in telehealth services.

Quality Improvement Plan for CY 2021			
Rate Goal for 2021 (State the 2021 rate goal from your MY2019 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 2020 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.*
Communication between Inpatient /consumer/outpatient	1. Explore the implementation of Project Red with two additional mental health inpatient providers 2. Develop a joint operating agreement to be used between mental health inpatient facilities and outpatient providers to ensure communications between the inpatient facilities, Members and outpatient providers and compliance with new value based purchasing (VBP) requirements.	12/31/2021	1. Maintain meeting minutes to track the Project Red expansion work, develop and maintain a work plan, and monthly reports on FUH and REA rates for the facilities that have implemented the model. 2. Maintain meeting minutes, use a pilot program for implementation, completion of the operating agreement and quarterly review of the FUH rates for the facilities and semi-annually review the VBP data.
Lack of follow-up outpatient appointments	1. Develop and implement ongoing communication protocol with all in network mental health inpatient providers on how to	12/31/2021	Development of the communication protocol, establishment of a timeline for the distribution of the communication protocol and maintain a log of the distribution.

Quality Improvement Plan for CY 2021			
	access the PerformCare Provider Directory and the various mental health outpatient provider resources		
Member inability to connect with telehealth service	1. Develop and distribute to all in network mental health providers and mental health outpatient providers a Telehealth Tool Kit that includes: a. An assessment tool to be used to determine a Member's ability and capacity to participate in telehealth services b. A protocol for addressing non-telehealth options c. A checklist of materials required to have a Member participate in the telehealth appointment d. A communication protocol for providers	12/31/21	Develop a work plan to track the development of the Tool Kit, approval and distribution of the Tool Kit and maintain a distribution or access log to track provider usage.

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

<table>
<tr><th colspan="2">RCA for MY 2019 Underperformance</th></tr>
<tr><td><u>Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):</u>
PerformCare used a series of internal and external workgroups made up of key stakeholders including Members Certified Peer Support Specialists and Providers to identify barriers to Member follow-up with mental health outpatient appointments.
The MY 2019 validated HEDIS FUH 30-day rates and data were used to analyze the population, diagnoses, and network providers experiencing the poor follow-up rates.
PerformCare also used the internal 2020 YTD (January to November) Quality Dashboards to analyze the data for CY 2020. Additional data analyze was completed using the PerformCare discharge assessment and follow-up after hospitalization (FUH) activities reports.
A comparative analysis was used to identify the drivers of the low follow-up rates and a barrier analysis was used to identify the barriers to Members completing follow-up outpatient appointments. The workgroup participants identified the top three barriers by voting on the identified barriers.
The workgroups used the top three barriers to identify interventions to address the barriers.</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 overall FUH data findings for MY 2019 and YTD 2020 data periods identified the following drivers of the low FUH rates:
1. CABHC Members
2. Adults (ages 18+)
3. The prominent diagnoses included Major Depressive Disorder, Schizophrenia / Psychosis, Bipolar disorder and Mood disorders
The findings also showed that Member FUH rates were higher when Targeted Care Management (TCM) was involved.
The top three barriers identified by the workgroups included:
1. Communication between Inpatient /consumer/outpatient
2. Lack of follow-up outpatient appointments
3. Member inability to connect with telehealth service
The interventions identified by the workgroups included:
1. Explore the implementation of Project Re-Engineered Discharge (Project RED) with two additional mental health inpatient providers
2. Develop a joint operating agreement to be used between mental health inpatient facilities and outpatient providers to ensure communications between the inpatient facilities, Members and outpatient providers and compliance with new value based purchasing requirements
3. Develop and implement ongoing communication protocol with all in network mental health inpatient providers on how to access the PerformCare Provider Directory and the various mental health outpatient provider resources
4. Develop and distribute to all in network mental health providers and mental health outpatient providers a Telehealth Tool Kit that includes:
a. An assessment tool to be used to determine a Member’s ability and capacity to participate in telehealth services
b. A protocol for addressing non-telehealth options
c. A checklist of materials required to have a Member participate in the telehealth appointment
d. A communication protocol for providers

Perform and the Primary Contractors did not complete an analysis on the racial and/or ethnic disparities. This type of analysis requires consideration of the total HealthChoices eligible population and PerformCare is in the process of defining the data model/process to fully and accurately capture the necessary data. Additionally, PerformCare anticipates that this will require a survey of the Members not currently receiving mental health services through PerformCare and a barrier analysis to determine any disparities.</td></tr>
</table>

RCA for MY 2019 Underperformance	
	The PerformCare HEDIS FUH 30-day rate goal is 75%.
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) Communication between Inpatient /consumer/outpatient	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members report showing up for follow-up appointments and being told there is no appointment scheduled, Members report having appointments cancelled and/or rescheduled prior to arriving for appointment, and incomplete communication of open access and walk-in opportunities. These factors cause follow-up appointments outside the 30-day measure. Critical
	Current and expected actionability: Improved communication of follow-up appointments resulting in Member attending the appointment.
People (2) Lack of follow-up outpatient appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members and Providers report a lack of appointments when attempting to schedule appointments within 30-days. First time appointments often require an in-person appointment and COVID restrictions limit the number of in-person appointments versus telehealth appointments. If appointments are not available, the 30-day follow-up cannot be met. Critical
	Current and expected actionability: Increased availability of in-person appointments and improvement in open access and walk-in appointments
People (3) Member inability to connect with telehealth service	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical
	Current and expected actionability: Improvement in Member engagement in telehealth services.
Providers (1) Communication between inpatient provider /consumer/outpatient provider	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members report showing up for follow-up appointments and being told there is no appointment scheduled, Members report having appointments cancelled and/or rescheduled prior to arriving for appointment, and incomplete communication of open access and walk-in opportunities. These factors cause follow-up appointments outside the 30-day measure. Critical
	Current and expected actionability: Improved communication of follow-up appointments resulting in

RCA for MY 2019 Underperformance	
	Member attending the appointment.
Providers (2) Lack of follow-up outpatient appointments	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members and Providers report a lack of appointments when attempting to schedule appointments within 30-days. First time appointments often require an in-person appointment and COVID restrictions limit the number of in-person appointments versus telehealth appointments. If appointments are not available, the 30-day follow-up cannot be met. Critical
	Current and expected actionability: Increased availability of in-person appointments and improvement in open access and walk-in appointments
Providers (3) Member inability to connect with telehealth service	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical
	Current and expected actionability: Improvement in Member engagement in telehealth services.
Policies / Procedures(1) Communication between Inpatient /consumer/outpatient	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Members report showing up for follow-up appointments and being told there is no appointment scheduled, Members report having appointments cancelled and/or rescheduled prior to arriving for appointment, and incomplete communication of open access and walk-in opportunities. These factors cause follow-up appointments outside the 30-day measure. Critical
	Current and expected actionability: Improved communication of follow-up appointments resulting in Member attending the appointment.
Policies / Procedures (2) Member inability to connect with telehealth service	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical
	Current and expected actionability: Improvement in Member engagement in telehealth services.
Provisions (1) *Member inability to connect with telehealth service*	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** In the current COVID environment, Members are expected to use telehealth for outpatient appointments Members report difficulties in connecting with telehealth services including lack of technology, data plans, equipment, and abilities / knowledge. Critical
	Current and expected actionability:

RCA for MY 2019 Underperformance	
	Improvement in Member engagement in telehealth services.

Quality Improvement Plan for CY 2021			
Rate Goal for 2021 (State the 2021 rate goal from your MY2019 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 2020 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.*
Communication between Inpatient /consumer/outpatient	1. Explore the implementation of Project Red with two additional mental health inpatient providers 2. Develop a joint operating agreement to be used between mental health inpatient facilities and outpatient providers to ensure communications between the inpatient facilities, Members and outpatient providers and compliance with new value based purchasing (VBP) requirements.	12/31/2021	1. Maintain meeting minutes to track the Project Red expansion work, develop and maintain a work plan, and monthly reports on FUH and REA rates for the facilities that have implemented the model. 2. Maintain meeting minutes, use a pilot program for implementation, completion of the operating agreement and quarterly review of the FUH rates for the facilities and semi-annually review the VBP data.
Lack of follow-up outpatient appointments	1. Develop and implement ongoing communication protocol with all in network mental health inpatient providers on how to access the	12/31/2021	Development of the communication protocol, establishment of a timeline for the distribution of the communication protocol and maintain a log of the distribution.

Quality Improvement Plan for CY 2021			
	PerformCare Provider Directory and the various mental health outpatient provider resources		
Member inability to connect with telehealth service	1. Develop and distribute to all in network mental health providers and mental health outpatient providers a Telehealth Tool Kit that includes: a. An assessment tool to be used to determine a Member's ability and capacity to participate in telehealth services b. A protocol for addressing non-telehealth options c. A checklist of materials required to have a Member participate in the telehealth appointment d. A communication protocol for providers	12/31/21	Develop a work plan to track the development of the Tool Kit, approval and distribution of the Tool Kit and maintain a distribution or access log to track provider usage.

VI: 2020 Strengths and Opportunities for Improvement

The section provides an overview of PerformCare's 2020 (MY 2019) performance in the following areas: structure and operations standards, PIPs (no MY 2019 results to report), and PMs, with identified strengths and opportunities for improvement.

Strengths

- PerformCare was compliant with the eponymous category in Quality Assessment and Performance Improvement Program.
- PerformCare's MY 2019 HEDIS 7-Day and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for the 6–17 years age band was significantly above the corresponding HC BH statewide averages.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2017, RY 2018, and RY 2019 found PerformCare to be partially compliant with two sections associated with Medicaid Managed Care regulations.
  - PerformCare was partially compliant with 3 out of 9 categories within Compliance with Standards, including Enrollee Rights and Protections. The partially compliant categories are: 1) Availability of Services, 2) Coverage and Authorization of Services, and 3) Practice Guidelines.
  - PerformCare was partially compliant with the single category of Grievance and Appeal Systems within Grievance System.
- PerformCare's MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- PerformCare's MY 2019 PA-Specific 7-Day Follow-Up After Hospitalization for Mental Illness rates (QI A) for the 6+ years age band was significantly below the corresponding Statewide averages.
- PerformCare's MY 2019 HEDIS 7-Day Follow-up After Hospitalization for Mental Illness rates (QI 1) for the 18-64 years age band was significantly below the corresponding Statewide averages.
- PerformCare's MY 2019 HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for the 6+ years and 18–64 years age band were significantly below the corresponding averages from MY 2018.
- PerformCare's MY 2019 PA-Specific 7-Day and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI A and QI B) for the 6+ years age band was significantly below the corresponding averages from MY 2018.

Performance Measure Matrices

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

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

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

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

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

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

Table 6.2: MY 2019 PA-Specific 7- and 30-Day Follow-up after Hospitalization and MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (Overall)

Quality Performance Measure	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2018 Rate	MY 2019 Rate	MY 2019 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-Up After Hospitalization for Mental Illness (Overall)	56.9% ═	51.6% ▼	51.4% ═	57.1% ▲	51.0% ▼	52.9% ▼
QI B – PA-Specific 30-Day Follow-Up After Hospitalization for Mental Illness (Overall)	75.6% ═	72.2% ▼	70.9% ═	74.9% ▲	69.7% ▼	69.5% ═
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	15.6% ═	15.4% ═	11.1% ▲	13.5% ▼	13.1% ═	13.5% ═

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

Table 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2019 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2019 HEDIS Overall (ages 6+ years) FUH 7-Day (QI1) and 30-Day Follow-up (QI2) After Hospitalization metrics. An RCA and QIP is required for rates that fall below the 75th percentile.

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

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

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

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

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

Quality Performance Measure	MY 2019		HEDIS MY 2019 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness (6–64 Years)	39.7%	Not met	Below 75th percentile, above 50th percentile
QI 2 – HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (6–64 Years)	60.7%%	Not met	Below 75th percentile, above 50th percentile

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

VII: Summary of Activities

Performance Improvement Projects

- PerformCare submitted a Final PIP Report in 2019.

Performance Measures

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

Structure and Operations Standards

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

Quality Studies

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

2019 Opportunities for Improvement MCO Response

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

2020 Strengths and Opportunities for Improvement

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

References

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

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

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

BBA Category	PEPS Reference	PEPS Language
Assurances of adequate capacity and services 42 C.F.R. § 438.207	Substandard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages). • Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.
Availability of Services 42 C.F.R § 438.206, 42 C.F.R. § 10(h)	Substandard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages). • Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.3	Provider Exception report submitted and approved when choice of two providers is not given.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.
	Substandard 1.7	Confirm FQHC providers.
	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English

BBA Category	PEPS Reference	PEPS Language
		members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Substandard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Confidentiality 42 C.F.R. § 438.224	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Coordination and continuity of care 42 C.F.R. § 438.208	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441,	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use

BBA Category	PEPS Reference	PEPS Language
Subpart B, and § 438.114		the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
Health information systems 42 C.F.R. § 438.242	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Practice guidelines 42 C.F.R. § 438.236	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Provider selection 42 C.F.R. § 438.214	Substandard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Substandard 10.2	100% of decisions made within 180 days of receipt of application.
	Substandard 10.3	Recredentialing incorporates results of provider profiling.
Subcontractual relationships and delegation 42 C.F.R. § 438.230	Substandard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
	Substandard 99.2	The BH-MCO reports monitoring results for adverse incidents.
	Substandard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as other medical and human services programs.
	Substandard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Substandard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Substandard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Substandard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Substandard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.

BBA Category	PEPS Reference	PEPS Language
Quality assessment and performance improvement program 42 C.F.R. § 438.330	Substandard 91.1	The QM Program Description clearly outlines the BH-MCO QM structure.
	Substandard 91.2	The QM Program Description clearly outlines the BH-MCO QM content.
	Substandard 91.3	The QM Program Description includes the following basic elements: Performance improvement projects Collection and submission of performance measurement data Mechanisms to detect underutilization and overutilization of services Emphasis on, but not limited to, high volume/high-risk services and treatment, such as Behavioral Health Rehabilitation Services Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs.
	Substandard 91.4	The QM Work Plan includes: Objective Aspect of care/service Scope of activity Frequency Data source Sample size Responsible person Specific, measurable, attainable, realistic and timely performance goals, as applicable.
	Substandard 91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	Substandard 91.6	The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.
	Substandard 91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	Substandard 91.8	The QM Work Plan includes a provider profiling process.
	Substandard 91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: Telephone access and responsiveness rates Overall utilization patterns and trends including BHRS and other high volume/high risk services.
	Substandard 91.1	The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.
	Substandard 91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Substandard 91.12	The QM Work Plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Evaluation
	Substandard 91.13	The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year

BBA Category	PEPS Reference	PEPS Language
	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, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.4 (RY 2016, 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the Grievance process, including how Grievance rights and procedures are made known to Members, BH-MCO staff and the provider network: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.2	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

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

Appendix B. OMHSAS-Specific PEPS Substandards

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

Table B.1: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Substandard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	Other: Significant onsite review findings related to Standard 28.
Complaints and Grievances		
Complaints	Substandard 68.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 68.1.2	Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.
	Substandard 68.5	A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Substandard 68.6	Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 68.6 (RY 2016, 2017)	The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	Substandard 68.7 (RY 2016, 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	Substandard 68.8	Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role.
Grievances	Substandard 71.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 71.1.2	Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.
	Substandard 71.5	A verbatim transcript and/or recording of the Grievance review meeting is

Category	PEPS Reference	PEPS Language
		maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members.
	Substandard 71.5 (RY 2016, 2017)	The second level grievance case file includes documentation that the member was contacted about the second level grievance meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	Substandard 71.6	Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 71.6 (RY 2016, 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements.
Executive Management		
County Executive Management	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/ Family Satisfaction	Substandard 108.3	County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program.
	Substandard 108.4	The C/FST Director is responsible for: setting program direction consistent with County direction; negotiating contract; prioritizing budget expenditures; recommending survey content and priority; and directing staff to perform high quality surveys.
	Substandard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling, and have resulted in provider action to address issues identified.

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

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

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

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

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
Category (PEPS Standard)	Total	NR	RY 2019	RY 2018	RY 2017
Care Management					
Care Management (CM) Staffing	1	0	0	0	1
Longitudinal Care Management (and Care Management Record Review)	1	0	0	0	1
Complaints and Grievances					
Complaints	4	0	0	0	4
Grievances	4	0	0	0	4
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	**16**		**1**	**3**	**12**

[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 sub-standards 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; NR: Sub-standards not reviewed; RY: review year.

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. PerformCare and its Primary Contractors were evaluated on 2 of the 2 applicable substandards. PerformCare was compliant with both substandards. The status for these substandards is presented in **Table C.2**.

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

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

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

Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances include MCO-specific and County-specific review standards. PerformCare and its Primary Contractors were evaluated on 8 of the 8 applicable substandards. Of the 8 substandards evaluated, PerformCare was compliant with 6 substandards and partially compliant with 2 substandards, as indicated 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	2017		All PerformCare Primary Contractors	
	Substandard 68.6 (RY 2016, 2017)	2017		All PerformCare Primary Contractors	
	Substandard 68.7 (RY 2016, 2017)	2017	All PerformCare Primary Contractors		
	Substandard 68.5	2017	All PerformCare Primary Contractors		

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Grievances	Substandard 71.1.1	2017	All PerformCare Primary Contractors		
	Substandard 71.5 (RY 2016, 2017)	2017	All PerformCare Primary Contractors		
	Substandard 71.6 (RY 2016, 2017)	2017	All PerformCare Primary Contractors		
	Substandard 71.5	2017	All PerformCare Primary Contractors		

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

PerformCare was partially compliant with Standard 68.1, Substandard 1 and Standard 68, Substandard 6

Standard 68.1: Complaint (and BBA Fair Hearing) rights and procedures are made known to IEAP, members, BH-MCO staff, and the provider network through manuals, training, handbooks, etc.

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

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

Substandard 6 (RY 2016, RY 2017): The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.

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. PerformCare was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

Table C.4: OMHSAS-Specific Requirements Relating to Denials

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Denials					
Denials	Substandard 72.3	2019	All PerformCare Primary Contractors		

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

Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a County-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. PerformCare and all its Primary Contractors were evaluated on both substandards and were found compliant. 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	2017	All PerformCare Primary Contractors		
BH-MCO Executive Management	Substandard 86.3	2017	All PerformCare Primary Contractors		

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

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 PerformCare counties and were compliant on all three substandards. The status by county for these 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	2018	All PerformCare Primary Contractors		
	Substandard 108.4	2018	All PerformCare Primary Contractors		
	Substandard 108.9	2018	All PerformCare Primary Contractors		

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