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

2019 External Quality Review Report
Community Behavioral Health

FINAL
April 2020

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Introduction

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

Overview

HealthChoices (HC) Behavioral Health (BH) is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO (Island Peer Review Organization) as its EQRO to conduct the 2019 EQRs for HC BH-MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO: Community Behavioral Health (CBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Objectives

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

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

Report Structure

This technical report includes seven core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures
IV. Quality Study
V. 2018 Opportunities for Improvement – MCO Response
VI. 2019 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, the information for compliance with the Structure and Operations Standards section of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity, when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. Information for Sections II and III of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure submissions. The Performance Measure validation, as conducted by IPRO, included a repeated measurement of three Performance Measures (PMs): Follow-up After Hospitalization for Mental Illness, Readmission Within 30 Days of Inpatient Psychiatric Discharge, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. Section V, 2018 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2018 (RY 2017) EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI includes a summary of the MCO's strengths and opportunities for improvement for this review period (RY 2018), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

Supplemental Materials

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

- the MCO's BBA Report for RY 2018, and
- the MCO's Annual PIP Review for RY 2018.

I: Structure and Operations Standards

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the structure and operations standards. In review year (RY) 2018, 67 Pennsylvania counties participated in this compliance evaluation.

Organization of the HealthChoices Behavioral Health Program

OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program, the mandatory managed care program that provides Medical Assistance recipients with services to treat mental health and/or substance abuse diagnoses/disorders. In such cases, the Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH Contractors, who, in turn, sub-contract with a private-sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Forty-three (43) of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a BH-MCO. Twenty-four (24) counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties.

In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH Contractors while providing an oversight function of the BH-MCOs. In some cases the HealthChoices Oversight Entity is the HealthChoices Behavioral Health (HC BH) Contractor and, in other cases, multiple HC BH Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. Operational reviews are completed for each HealthChoices Oversight Entity. The HC BH Contractor, whether contracting with an Oversight Entity arrangement or not, is responsible for their regulatory compliance to federal and state regulations and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the HC BH Contractor's responsibility for the oversight of BH-MCO's compliance.

The City of Philadelphia and Philadelphia County share a common border. As such, the City of Philadelphia is the HealthChoices Oversight Entity and the HC BH Contractor that holds an agreement with Community Behavioral Health (CBH). CBH is a county-operated BH-MCO. Members enrolled in the HealthChoices Behavioral Health Program in Philadelphia County are assigned CBH as their BH-MCO. The EQR for structure and operations standards is based on OMHSAS reviews of Philadelphia County and CBH.

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 CBH by OMHSAS monitoring staff within the past three review years (RYs 2018, 2017, and 2016). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2018. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year time frame under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2018 and entered into the PEPS Application as of March 2019 for RY 2018. Information captured in the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to capture additional reviewer comments. Based on the PEPS Application, a HealthChoices Oversight Entity/BH-MCO is evaluated against

substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS's more rigorous monitoring criteria.

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

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

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The RY 2018 crosswalks of PEPS Substandards to pertinent BBA regulations and to pertinent OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The three-year period is alternatively referred to as the Active Review period. The PEPS Substandards from RY 2018, RY 2017, and RY 2016 provided the information necessary for the 2018 assessment. Those triennial standards not reviewed through the PEPS system in RY 2018 were evaluated on their performance based on RY 2017 and/or RY 2016 determinations, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year time frame under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

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

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CBH

Table 1.1 tallies the PEPs Substandard reviews used to evaluate the HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2016–2018). Substandard counts under RY 2018 include both annual and triennial substandards; Substandard counts under RYs 2017 and 2016 are comprised only of triennial substandards. By definition, only the last review of annual substandards is counted in the three-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in Table 1.1, 175, differs from the unique count of substandards that came under active review (79).

Table 1.1: Tally of Substandards Pertinent to BBA Regulations Reviewed for CBH

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2018	RY 2017	RY 2016
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	14	0	4	7	3
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	N/A	N/A	N/A	N/A	N/A
Liability for Payment	0	0	0	0	0
Cost Sharing	0	0	0	0	0
Emergency and Post-Stabilization Services	0	0	0	0	0
Solvency Standards	0	0	0	0	0
Subpart D: Quality Assessment and Performance Improvement					
Elements of State Quality Strategies	0	0	0	0	0
Availability of Services	24	0	9	13	2
Coordination and Continuity of Care	2	0	0	0	2
Coverage and Authorization of Services	4	0	2	0	2
Provider Selection	3	1	0	2	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	0	4	0	2
Quality Assessment and Performance Improvement Program	26	0	26	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	0	2	0	9
General Requirements	14	0	2	0	12
Notice of Action	13	0	7	6	0
Handling of Grievances and Appeals	11	0	2	0	9
Resolution and Notification: Grievances and Appeals	11	0	2	0	9
Expedited Appeals Process	6	0	2	0	4
Information to Providers and Subcontractors	9	0	0	0	9
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	2	0	4
Effectuation of Reversed Resolutions	6	0	2	0	4
Total	175	1	75	28	71

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

[2] The number of 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, 175, differs from the unique count of substandards that came under active review (79).

BBA: Balanced Budget Act; CBH: Community Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: Substandards not reviewed; N/A: Category not applicable.

For RY 2018, nine of the above categories – 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements – were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS's judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH-MCOs. The category of Marketing Activities is Not Applicable because, as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per county.

Compliance for the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50–447.60.

Before 2008, the categories of Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all HC BH Contractors and BH-MCOs based on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. In 2008, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories. For this 2019 (RY 2018) report, IPRO reviewed the Solvency tracking reports and the quarterly reporting of Complaint and Grievances data to determine compliance with Solvency and Recordkeeping and Recording Requirement, respectively.

Determination of Compliance

To evaluate HealthChoices Oversight Entity/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision (category) and evaluated the HC BH Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met, or not met in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HealthChoices Oversight Entity/BH-MCO, it was assigned a value of not determined. Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the PEPS items linked to each provision. If all items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. A value of null was assigned to a provision when none of the existing PEPS Substandards directly covered the items contained in the provision, or if it was not covered in any other documentation provided. Finally, all compliance results in a given category were aggregated to arrive at a summary compliance status for the category. For example, all compliance findings relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Format

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

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

Findings

Seventy-nine unique PEPS Substandards were used to evaluate CBH and Philadelphia County compliance with BBA regulations in RY 2018.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each HC BH Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the HC BH Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees (42 CFR 438.100 [a], [b]). **Table 1.2** presents the findings by categories.

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

Table 1.2: Compliance with Enrollee Rights and Protections Regulations

Subpart C: Categories	MCO Compliance Status	Comments
Enrollee Rights 438.100	Partial	14 substandards were crosswalked to this category. Philadelphia County was evaluated on 14 substandards, compliant with 12 substandards, and non-compliant with 2 substandards.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections II-5 F.7 and section II-4 A.5.a.
Marketing Activities 438.104	N/A	Not applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their county of residence.
Liability for Payment 438.106	Compliant	Compliant as per PS&R sections II-7 A.5.a and A.9-A.10.
Cost Sharing 438.108	Compliant	Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50–447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	Compliant as per PS&R sections II-4 A.4, B.6 and C.2.
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections II-7 A and the 2018–2019 Solvency Requirements tracking reports.

MCO: managed care organization; PS&R: N/A: not applicable; PS&R: Program Standards and Requirements; CMS: Centers for Medicare and Medicaid Services; BH: behavioral health; CFR: Code of Federal Regulations.

There are seven (7) categories within Subpart C Enrollee Rights and Protections. CBH was compliant with 5 categories and partially compliant with 1 category. The remaining category was considered not applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the 5 compliant categories, 3 were compliant as per the HealthChoices PS&R and 1 category was compliant as per CMS Regulation 42 CFR 447.50–447.60. The remaining category, Solvency Standards, was compliant based on the 2018–2019 Solvency Requirement tracking reports and the HealthChoices PS&R. Of the substandards that were crosswalked to Enrollee Rights and Protections Regulations, Philadelphia County was evaluated and compliant with 12 PEPS Substandards and non-compliant with 2 Substandards. Overall, Philadelphia County was deemed partially compliant for the category of Enrollee Rights. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Enrollee Rights

Philadelphia County was partially compliant with Enrollee Rights and Protections due to non-compliance with Substandards of PEPS Standard 60 (RY 2016).

PEPS Standard 60:

- The BH-MCO shall identify a lead person responsible for overall coordination of the complaint and grievance process, including the provision of information and instructions to members [Appendix H, A.,9., p.1]. (Responsibility includes Health Insurance Portability and Accountability Act of 1996 [HIPAA] Privacy duties related to complaints and mechanisms for tracking and reporting of HIPAA related complaints.)
- The BH-MCO shall designate and train sufficient staff responsible for receiving, processing, and responding to member complaints and grievances in accordance with the requirements contained in Appendix H [Appendix H, A., 8., p. 1].
- All BH-MCO staff shall be educated concerning member rights and the procedure for filing complaints and grievances [C.4., p. 44].
- The BH-MCO must have written policies and procedures for registering, responding to and resolving Complaints and Grievances.

Philadelphia County was non-compliant with Substandards 2 and 3 of Standard 60 (RY 2016).

Substandard 2: Training rosters identify that Complaint and Grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum.

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

Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid Managed Care program, the HealthChoices Program, are available and accessible to MCO enrollees [42 CFR 438.206 (a)].

The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart D. Based on the items reviewed for the 10 categories of Quality Assessment and Performance Improvement Regulations, Philadelphia County was fully compliant with 4 categories, partially compliant with 4 categories, and non-compliant with 2 categories. Philadelphia County was evaluated and deemed compliant with the categories of Elements of State Quality Strategies and Confidentiality per the HealthChoices PS&R, as these categories were not directly addressed by any PEPS Substandards.

Of the PEPS items crosswalked to Quality Assessment and Performance Improvement regulations, 74 were evaluated for Philadelphia County for RY 2018. CBH and Philadelphia County were compliant with 50 PEPS items, partially compliant with 4 PEPS item, and non-compliant with 19 PEPS items. One substandard under Provider Selection was not applicable to CBH and therefore not reviewed. **Table 1.3** presents the findings by categories consistent with the regulations.

Table 1.3: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	Comments
Elements of State Quality Strategies 438.204	Compliant	Compliant as per PS&R sections II-5 G and II-6 A and B.3.
Availability of Services (Access to Care) 438.206	Partial	24 substandards were crosswalked to this category. Philadelphia County was evaluated on 24 substandards, compliant with 18 substandards, partially compliant with 1 substandard, and non-compliant with 5 substandards.
Coordination and Continuity of Care 438.208	Non-compliant	2 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards and non-compliant with 2 substandards.
Coverage and Authorization of Services 438.210	Non-compliant	4 substandards were crosswalked to this category. Philadelphia County was evaluated on 5 substandards and non-compliant with 4 substandards.
Provider Selection 438.214	Partial	3 substandards were crosswalked to this category. Philadelphia County was evaluated on 2 substandards, compliant with 1 substandard, non-compliant with 1 substandard, and not applicable with 1 substandard.
Confidentiality 438.224	Compliant	Compliant as per PS&R sections II-4 B, C.6, D.3, and G.4, II-6 B.3, II-7 K.4.
Subcontractual Relationships and Delegation 438.230	Compliant	8 substandards were crosswalked to this category. Philadelphia County was evaluated on 8 substandards and compliant with 8 substandards.
Practice Guidelines 438.236	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 2 substandards, and non-compliant with 4 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial	26 substandards were crosswalked to this category. Philadelphia County was evaluated on 26 substandards, compliant with 20 substandards, partially compliant with 3 substandards, and non-compliant with 3 substandard.
Health Information Systems 438.242	Compliant	1 substandard was crosswalked to this category. Philadelphia County was evaluated on 1 substandard and compliant with this substandard.

MCO: managed care organization; PS&R: Program Standards and Requirements.

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

Availability of Services (Access to Care)

Philadelphia County was partially compliant with Availability of Services (Access to Care) due to partial and non-compliance with substandards of PEPS Standards 1, 28 (RY 2016), and (RY 2018).

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

Philadelphia County was partially compliant with Substandard 1 and non-compliant with Substandard 6 (RY 2017).

Substandard 1:

- A complete listing of all contracted and credentialed providers.
- Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care.
- Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages).
- Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (adult, child & adolescent); Priority Population; Special Population.

Substandard 6: BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.

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

Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

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.

PEPS Standard 93: The BH-MCO Evaluates the Effectiveness of Services received by Members. Evaluate effectiveness of the services received by members and changes made when necessary to access services, provider network adequacy, appropriateness of service authorization, inter-rater reliability, complaint, grievance and appeal process, and treatment outcomes.

Philadelphia County was non-compliant with Substandards 3 and 4 of Standard 93 (RY 2018).

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

Substandard 4: The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.

Coordination and Continuity of Care

Philadelphia County was non-compliant with Coordination and Continuity of Care due to non-compliance with substandards of PEPS Standard 28 (RY 2016).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care). Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

Coverage and Authorization of Services

Philadelphia County was non-compliant with Coverage and Authorization of Services due to non-compliance with substandards of PEPS Standard 28 (RY 2016) and 72 (RY 2018).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care). Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

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

Attachments 2a, 2b, 2c, and 2d]. Philadelphia County was non-compliant with Substandards 1 and 2 of PEPS Standard 72 (RY 2018).

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

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

Provider Selection

Philadelphia County was partially compliant with Provider Selection due to non-compliance with substandard 3 of PEPS Standard 10 (RY 2017). Substandard 2 PEPS Standard 10 (RY 2017) was not applicable and was therefore not reviewed.

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

Substandard 3: Recredentialing incorporates results of provider profiling.

Practice Guidelines

Philadelphia County was partially compliant with Practice Guidelines due to non-compliance with substandards of PEPS Standard 28 (RY 2016) and Standard 93 (RY 2018).

PEPS Standard 28: See Standard description and determination of compliance under Availability of Services (Access to Care). Philadelphia County was non-compliant with Substandards 1 and 2 of Standard 28 (RY 2016).

PEPS Standard 93: See Standard description and determination of compliance under Availability of Services (Access to Care). Philadelphia County was non-compliant with Substandards 3 and 4 of Standard 93 (RY 2018).

Quality Assessment and Performance Improvement

Philadelphia County was partially compliant with Quality Assessment and Performance Improvement due to partial compliance and non-compliance with substandards of PEPS Standards 91 and 93 (RY 2018).

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

Substandard 1: QM program description outlines ongoing quality assessment, performance improvement activities, a continuous quality improvement process, and places emphasis on, but not limited to, high-volume/high-risk services and treatment and BHRS.

Substandard 4: QM work plan outlines the joint studies to be conducted.

Substandard 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 15: The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's QM 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.

PEPS Standard 93: See Standard description and determination of compliance under Availability of Services (Access to Care). Philadelphia County was non-compliant with Substandards 3 and 4 of Standard 93 (RY 2018).

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances.

The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. Based on the Substandards reviewed, Philadelphia County was fully compliant with 1 of the 10 evaluated categories of Federal and State Grievance System Standards regulations, and partially compliant with the other 8 categories. In the category of Recordkeeping and Recording Requirements, Philadelphia County was compliant per quarterly reporting of complaints and grievances. In all, 87 PEPS items were crosswalked to Federal and State Grievance System Standards, and Philadelphia County was evaluated on 87 items. Philadelphia County was fully compliant with 39 items, partially compliant with 22 items, and non-compliant with 26 items. **Table 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	Comments
Statutory Basis and Definitions 438.400	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 4 substandards, and non-compliant with 4 substandards.
General Requirements 438.402	Partial	14 substandards were crosswalked to this category. Philadelphia County was evaluated on 14 substandards, compliant with 4 substandards, partially compliant with 4 substandards, and non-compliant with 6 substandards.
Notice of Action 438.404	Partial	13 substandards were crosswalked to this category. Philadelphia County was evaluated on 13 substandards, compliant with 11 substandards, and non-compliant with 2 substandards.
Handling of Grievances and Appeals 438.406	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 4 substandards, and non-compliant with 4 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial	11 substandards were crosswalked to this category. Philadelphia County was evaluated on 11 substandards, compliant with 3 substandards, partially compliant with 4 substandards, and non-compliant with 4 substandards.
Expedited Appeals Process 438.410	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 2 substandards, partially compliant with 2 substandards, and non-compliant with 2 substandards.
Information to Providers & Subcontractors 438.414	Compliant	8 substandards were crosswalked to this category. Philadelphia County was evaluated on 8 substandards and compliant with 8 substandards.
Recordkeeping and Recording Requirements 438.416	Compliant	Compliant as per the required quarterly reporting of complaint and grievances data.
Continuation of Benefits 438.420	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 2 substandards, partially compliant with 2 substandards, and non-compliant with 2 substandards.
Effectuation of Reversed Resolutions 438.424	Partial	6 substandards were crosswalked to this category. Philadelphia County was evaluated on 6 substandards, compliant with 2 substandards, partially compliant with 2 substandards, and non-compliant with 2 substandards.

MCO: managed care organization.

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

Statutory Basis and Definitions

Philadelphia County was partially compliant with Statutory Basis and Definitions due to non-compliance and partial compliance with substandards of PEPS Standards 68, 71 (RY 2016) and 72 (RY 2018).

PEPS Standard 68: The Complaint and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Philadelphia County was non-compliant with Substandards 3 and 9 and partially compliant with Substandards 3 and 4 (RY 2016, 2017) of Standard 68 (RY 2016).

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 (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 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 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.

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

Philadelphia County was partially compliant with Substandards 3 and 9 of Standard 71 (RY 2016).

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

PEPS Standard 72: See Standard and description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandards 1 and 2 of PEPS Standard 72 (RY 2018).

General Requirements

Philadelphia County was partially compliant with General Requirements due to partial compliance and non-compliance with substandards of PEPS Standards 60, 68, 71(RY 2016), and 72 (RY 2018).

PEPS Standard 60: See Standard description and determination of compliance under Enrollee Rights and Protections (Enrollee Rights). Philadelphia County was non-compliant with Substandards 2 and 3 of Standard 60 (RY 2016).

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was non-compliant with Substandards 2 and 5 and partially compliant with Substandards 3 and 4 of Standard 68 (RY 2016).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2018).

Notice of Action

Philadelphia County was partially compliant with Notice of Action due to non-compliance with substandards of PEPS Standard 72 (RY 2018).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandards 1 and 2 of PEPS Standard 72 (RY 2018).

Handling of Grievances and Appeals

Philadelphia County was partially compliant with Handling of Grievances and Appeals due to partial compliance and non-compliance with substandards of PEPS Standards 68, 71 (RY 2016), and 72 (RY 2018).

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was non-compliant with Substandards 2 and 5 and partially compliant with Substandards 3 and 4 of Standard 68 (RY 2016).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2018).

Resolution and Notification: Grievances and Appeals

Philadelphia County was partially compliant with Resolution and Notification of Grievances and Appeals due to partial compliance and non-compliance with substandards of PEPS Standards 68, 71 (RY 2016), and 72 (RY 2018).

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was non-compliant with Substandards 2 and 5 and partially compliant with Substandards 3 and 4 of Standard 68 (RY 2016).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2018).

Expedited Appeals Process

Philadelphia County was partially compliant with Expedited Appeals process due to partial compliance and non-compliance with substandards of PEPS Standards 71 (RY 2016) and 72 (RY 2018).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2018).

Continuation of Benefits

Philadelphia County was partially compliant with Continuation of Benefits due to partial compliance and non-compliance with substandards of PEPS Standards 71 (RY 2016) and 72 (RY 2018).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2018).

Effectuation of Reversed Resolutions

Philadelphia County was partially compliant with Effectuation of Reversed Resolutions due to partial compliance and non-compliance with substandards of PEPS Standards 71 (RY 2016) and 72 (RY 2018).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. Philadelphia County was partially compliant with Substandards 2 and 4 of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. Philadelphia County was non-compliant with Substandard 1 and 2 of PEPS Standard 72 (RY 2018).

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, HC BH Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or re-measurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2019 for 2018 activities.

Background

A new EQR PIP cycle began for MCOs and HC BH Contractors in 2014. For this PIP cycle, OMHSAS selected the topic "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis" as the topic for this PIP. The topic was selected because the Aggregate HC BH 30-day Readmission Rate had consistently not met the OMHSAS goal of a rate of 10% or less. In addition, in 2014, all MCOs were below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS®) Follow-up After Hospitalization (FUH) metrics.

The Aim Statement for this PIP is "Successful transition from inpatient care to ambulatory care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis." OMHSAS selected three common objectives for all MCOs:

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.
2. Increase kept ambulatory follow-up appointments post-inpatient discharge.
3. Improve medication adherence post-inpatient discharge.

Additionally, OMHSAS required all MCOs to submit the following core performance measures on an annual basis:

1. **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Mental Health Discharges) (BHR-MH):** The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days without a substance abuse diagnosis during the initial stay.
2. **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Substance Abuse Discharges) (BHR-SA):** The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days with a substance abuse diagnosis (primary or secondary) during the initial stay.
3. **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA):** The percentage of members diagnosed with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is based on the HEDIS measure of the same name.
4. **Components of Discharge Management Planning (DMP):** This measure is based on review of facility discharge management plans and assesses the following:
    a. The percentage of discharge plans, including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses, and provider phone numbers.
    b. The percentage of discharge plans, including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses, and provider phone numbers, where at least one of the scheduled appointments occurred.

This PIP project extended from January 2015 through December 2018, with initial PIP proposals submitted in 2014 and a final report due in June 2019. In 2016, OMHSAS elected to add an additional intervention year to the PIP cycle to allow sufficient time for the demonstration of outcomes. The non-intervention baseline period was from January 2014 to December 2014. MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. MCOs were required to submit interim reports in 2016 and 2017. MCOs were required to submit an additional interim report in 2018, as well as a final report in 2019. MCOs are required to develop performance indicators

and implement interventions based on evaluations of HC BH Contractor-level and MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a collaboration between the HC BH Contractors and MCOs. The MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contractor-level data and illustrate how HC BH Contractor knowledge of their high-risk populations contributes to addressing the barriers within their specific service areas. Each MCO will submit the single root-cause/barrier analysis according to the PIP schedule. This PIP was formally introduced to the MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4, 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the MCOs and HC BH Contractors, as needed.

The 2019 EQR is the 16th review to include validation of PIPs. With this PIP cycle, all MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given to the MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. The MCOs were expected to implement the interventions that were planned in 2014, monitor the effectiveness of their interventions, and to improve their interventions based on their monitoring results.

The MCOs were required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol in *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology
- Data/Results
- Analysis Cycle
- Interventions

In 2016, OMHSAS elected to begin conducting quarterly PIP review calls with each MCO. The purpose of these calls was to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. Plans were asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, MCOs were asked to submit only one PIP interim report starting in 2016, rather than two semiannual submissions.

Validation Methodology

IPRO's validation of PIP activities occurring in 2018 was consistent with the protocol issued by CMS (*EQR Protocol 3: Validating Performance Improvement Projects [PIPs], Version 2.0, September 2012*) and met the requirements of the final rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 10 review elements listed below:

1. Project Topic and Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation of Study Results (Demonstrable Improvement)
9. Validity of Reported Improvement
10. Sustainability of Documented Improvement

The first 9 elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for

each element is based on full, partial, and non-compliance. As calendar year 2018 was the final intervention year for all MCOs), IPRO reviewed all 10 elements, including sustained improvement, for each MCO.

Review Element Designation/Weighting

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

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are awarded for the two phases of the project noted above and are combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. **Table 2.1** presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1: Review Element Scoring Designations and Definitions

Element Designation	Definition	Weight
Met	Met or exceeded the element requirements	100%
Partially met	Met essential requirements, but is deficient in some areas	50%
Not met	Has not met the essential requirements of the element	0%

Overall Project Performance Score

The total points earned for each review element are weighted to determine the MCO's overall performance score for a PIP. Review elements 1 through 9 are for demonstrable improvement and have a total weight of 80% (**Table 2.2**). The 10th element, Sustained Improvement, contributes the remaining 20%, and the highest achievable score for overall project performance is 100 points. The MCO must sustain improvement relative to the baseline after achieving demonstrable improvement.

Table 2.2: Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic and Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4/5	Identified Study Population and Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8/9	Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	20%
Total Demonstrable Improvement Score		80%
10	Sustainability of Documented Improvement	20%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements that have been completed during the review year. At the time of the review, a project is reviewed only for elements that are due according to the PIP submission schedule. The project will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule. At the time each PIP element is reviewed, a finding is given of "met," "partially met," or "not met." Elements receiving a finding of "met" will receive 100% of the points assigned to the element, "partially met" elements will receive 50% of the assigned points, and "not met" elements will receive 0%.

Findings

MCO submitted their Final PIP Report for review in September 2019. IPRO provided feedback and comments to MCO on this submission. **Table 2.3** presents the PIP scoring matrix for this Final Report submission, which corresponds to the key findings of the review described in the following paragraphs. CBH received a total demonstrable improvement score of 62.5 out of 80 points (78.1%) and a sustained improvement score of 10 out of 20 points (50%) for an overall project performance score of 72.5 of 100 (72.5%). CBH's overall compliance with the PIP requirements was therefore a Partial Met.

Table 2.3: PIP Scoring Matrix: Successful Transition from Inpatient to Ambulatory Care

Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 – Project Topic and Relevance	M	100	5%	5
Review Element 2 – Study Question (AIM Statement)	M	100	5%	5
Review Element 3 – Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 – Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 – Data Collection Procedures	M	100	10%	10
Review Element 7 – Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**62.5**
Review Element 10 – Sustainability of Documented Improvement	PM	50	20%	10
TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**10**
OVERALL PROJECT PERFORMANCE SCORE			**100%**	**72.5**

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

As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The MCO was compliant or met its performance goals with regard to review element 1. There were no issues or concerns with the requirements for the MCO topic and identifiers. Moreover, there were no concerns regarding: PIP topic and relevance; the BH-MCO provided a robust rationale for the topic chosen, and successfully described the foci of improvement efforts and the various interventions planned that address key aspects of care. The MCO had no issues or concerns with requirements for the aim statement. That is, the four objectives from the project proposal are clearly noted and the BH-MCO clearly defined the outcome and process measures that will be completed for the PIP. There were no issues or concerns identified with the methodology section insofar as each outcome measure and process measure was linked to a PIP objective. These three performance indicators are noted: behavioral health readmissions; medication adherence for schizophrenics; and discharge management planning. Moreover, methodology plans to ensure an adequate sample of substance abuse and mental health treatment patients for the study were sufficient. Furthermore, there were no concerns or issues with the PIP study methodology overall; that is, methods of data collection and data sources and timelines are successfully fleshed out.

The MCO was partially compliant with the barrier analysis and intervention element of the PIP. These barriers to successful implementation are noted in the PIP: missed follow up appointments which are correlated with lower

prescription adherence; younger members that have higher readmission rates than older members; higher readmission for males relative to females; and members with a schizophrenia diagnosis have high readmission rates.

The MCO was also partially compliant with the interpretation of results and the validity of reported improvement. The results were mixed: there was improvement in some metrics and none in others. Where improvements were noted, there was, at best, circumstantial evidence suggesting improvements were the result of the intervention(s). Other cases where either improvements were not statistically significant or there was worsening were more difficult to link to interventions. For example, might readmissions have increased even more over the course of the PIP in the absence of the interventions? Discussion appropriately acknowledged the existing of extraneous factors, which complicates the analysis. The discussion regarding the explanation of results was very thorough in documenting the implementation pitfalls and what succeeded and what did not. Nevertheless, the record on performance improvement for this PIP was mixed. For example, these positive trends were noted: readmission in the baseline year was 11% and by 2017 was at 13%; aftercare planning had improved and schizophrenic antipsychotic adherence had improved from 53% to 59% as well. Early episodes psychosis readmission rate and length of stay (LOS) has improved. Conversely, there were no significant changes in the readmission rate for 314 enrollees, no improvement in long-acting injectables, and although the intervention of text-based reminders showed early signs of leading to improvement, the MCO stopped carrying out this intervention due to low enrollments (<5%).

With regard to the abstract and discussion results, the MCO proposed next steps and quality improvements. One such proposal is a plan for expanding financial incentives (such as an enhanced outpatient rate for MH services within 7 and 30 days of discharge) to more successfully engage its network in these and similar interventions. It is important to note that other systemic changes, however, receive less discussion, including the strategic alignment of interventions to leverage synergies or efficiencies between them. Finally, in terms of the percentage change in performance improvement manifested over the course of the PIP, the MCO did not evidence significant improvement in the BHR and SAA indicators. No p-value was calculable for DMP because samples were drawn at the facility-level and therefore not generalizable at the BH-MCO level.

Summarizing, CBH's PIP benefitted generally from good planning and theory of quality improvement. However, the MCO did not adequately consider alternative interventions, or make successful midstream corrections. Ultimately, although some improvements were made in underlying discharge management- and follow-up care processes, the PIP did not realize significant performance improvement in the performance indicators. By extension, achievement of PIP objectives was incomplete.

III: Performance Measures

In 2019, OMHSAS and IPRO conducted three EQR studies. Both the Follow-up After Hospitalization for Mental Illness (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were re-measured in 2018. OMHSAS also elected to implement a statewide measure that focuses on substance abuse services, based on the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure.

Follow-up After Hospitalization for Mental Illness

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

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

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

Measure Selection and Description

In accordance with DHS guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population 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 performance measure assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge.

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

Eligible Population

The entire eligible population was used for all 29 HC BH Contractors participating in the MY 2018 study. Eligible cases were defined as those members in the HealthChoices 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, 2018;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2018, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified, are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as

the subsequent discharge is on or before December 1, 2018. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2019 methodology for the Follow-up After Hospitalization for Mental Illness measure.

HEDIS Follow-up Indicators

Quality Indicator 1 (QI 1): Follow-up After Hospitalization for Mental Illness Within 7 Days After Discharge (Calculation based on Industry Standard codes used in HEDIS)

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

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

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

PA-Specific Follow-up Indicators

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

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

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

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

Quality Indicator Significance

According to the *Global Burden of Disease: 2004 Update* released by the World Health Organization in 2008, mental illnesses and mental disorders represent 6 of the 20 leading causes of disability worldwide. Among developed nations, depression is the leading cause of disability for people ages 0–59 years, followed by drug and alcohol use disorders and psychoses (e.g., bipolar disorder and schizophrenia; World Health Organization, 2008). Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities (Dombrovski & Rosenstock, 2004; Moran, 2009) such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns (Gill, 2005; Leslie & Rosenheck, 2004), reduced use of preventive services (Druss et al., 2002), and substandard medical care that they receive (Desai et al., 2002; Druss et al., 2000; Frayne et al., 2005). Moreover, these patients are 5 times more likely to become homeless than those without these disorders (Averyt et al., 1997). On the whole, serious mental illnesses account for more than 15% of overall disease burden in the United States (National Institute of Mental Health, 2009), and they incur a growing estimate of $317 billion in economic burden through direct (e.g., medication, clinic visits, or hospitalization) and indirect (e.g., reduced productivity and income) channels (Insel, 2008). For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcome and to prevent long-term deterioration in people with severe and persistent mental illness (D'Mello et al., 1995). As noted in *The State of Health Care Quality Report* (NCQA, 2007), appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses, and the likelihood of recurrence. An outpatient visit within at least 30 days (ideally, 7 days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments (van Walraven et al., 2004). With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services (Hermann, 2000). One way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact (Hermann, 2000).

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of behavioral health care systems, with some researchers having estimated that 40-60% of patients fail to connect with an outpatient clinician (Cuffel et al., 2002). Research has demonstrated that patients who do not have an outpatient appointment after discharge were 2 times more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment (Nelson et al., 2000). Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow-up with outpatient care (Nelson et al., 2000). Patients who received follow-up care were also found to have experienced better quality of life at endpoint, better community function, lower severity of symptoms, and greater service satisfaction (Adair et al., 2005). Patients with higher functioning, in turn, had significantly lower community costs, and improved provider continuity was associated with lower hospital (Mitton et al., 2005) and Medicaid costs (Chien et al., 2000).

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, re-hospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment (Chien et al., 2000). Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services.

As noted, this measure and the issue of follow-up have been and remain of interest to OMHSAS, and results are reviewed for potential trends each year. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

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

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2018 (MY 2017), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a three-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 BBA report. Due to this change in the goal-setting method, no goals were set for MY 2018.

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

Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HealthChoices Aggregate (Statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the Statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2017 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *z* statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

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

Where:

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

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

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

Where:

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

Two-tailed statistical significant tests were conducted at *p* value = 0.05 to test the null hypothesis of:

$$H_0: p1 = p2$$

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

Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2018. Due to data quality concerns with identifying the Medicaid expansion subpopulation, however, the decision was made not to compare rates for this subpopulation; thus, any potential impacts on rates from the Medicaid expansion were not evaluated for MY 2018.

Limitations

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

Findings

BH-MCO and HC BH Contractor Results

The HEDIS follow-up indicators are presented for three age groups: ages 18 to 64, ages 6 and older, and ages 6 to 17. The 6+ years old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6 to 17 years old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

The results are presented at the BH-MCO- and HC BH-Contractor level. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and HC BH Contractor with the same contracted BH-MCO). The HC BH Contractor-specific rates were calculated using the numerators and denominators for that particular HC BH Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HealthChoices BH Aggregate (Statewide) rates were also calculated for the indicators.

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

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

I: HEDIS Follow-up Indicators

(a) Age Group: 18–64 Years Old

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

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

MY 2018							MY 2018 Rate Comparison To MY 2017	
				95% CI		MY 2017 %		
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD
QI1 - HEDIS 7-Day Follow-up (18-64 Years)								
HealthChoices (Statewide)	11,347	31,939	35.5%	35.0%	36.1%	35.3%	0.3	NO
CBH	1,355	6,165	22.0%	20.9%	23.0%	25.7%	-3.7	YES
Philadelphia	1,355	6,165	22.0%	20.9%	23.0%	25.7%	-3.7	YES
QI2 - HEDIS 30-Day Follow-up (18-64 Years)								
HealthChoices (Statewide)	17,896	31,939	56.0%	55.5%	56.6%	56.3%	-0.3	NO
CBH	2,232	6,165	36.2%	35.0%	37.4%	40.8%	-4.6	YES
Philadelphia	2,232	6,165	36.2%	35.0%	37.4%	40.8%	-4.6	YES

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator: PPD: percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

For MY 2018, CBH was subcontracted to provide behavioral health services to only one county located in the Southeast region of the Commonwealth – Philadelphia County; therefore, the CBH performance comprises the BH-MCO performance for Philadelphia County alone.

The MY 2018 HealthChoices QI 1 rate for members age 18 to 64 years was 35.5% compared to 35.3% in 2017 while QI 2 rate was 56.0% compared to 56.3% in 2017. The MY 2018 CBH/Philadelphia QI 1 rate for members was 22.0% compared to 25.7% in MY 2017. The QI 1 rate was statistically significantly lower than the MY 2017 CBH/Philadelphia QI 1 rate by 3.7 percentage points. The MY 2018 CBH/Philadelphia QI 2 rate for this age group was 36.2% compared to 40.8% in MY 2017. The QI 2 rate was statistically significantly lower than the MY 2017 CBH/Philadelphia QI 2 rate by 4.6 percentage points.

Figure 3.1 is a graphical representation of the MY 2018 HEDIS follow-up rates in the 18 to 64 years old population for CBH and its associated HC BH Contractor. The orange line represents the MCO average.

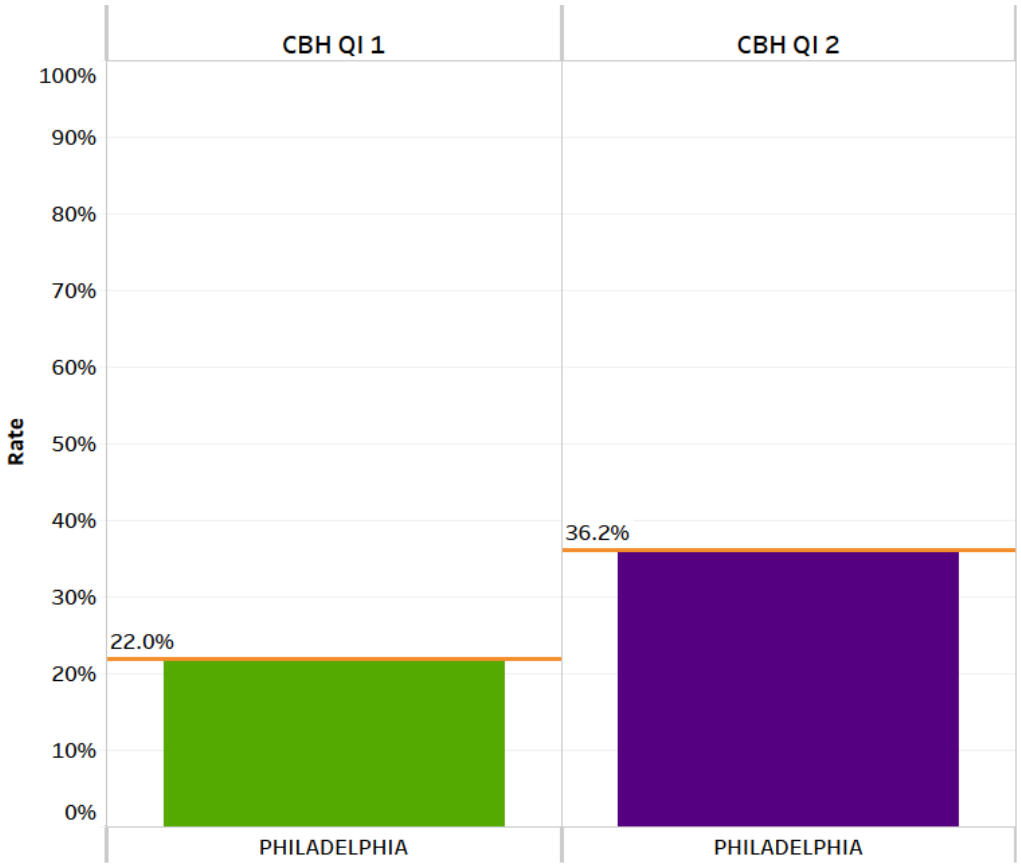

Figure 3.1: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (18–64 Years).

Figure 3.2 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The QI 1 rate for Philadelphia County was statistically significantly below the MY 2018 QI 1 HealthChoices (Statewide) rate of 35.5% by 13.5 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 56.0% by 19.8 percentage points.

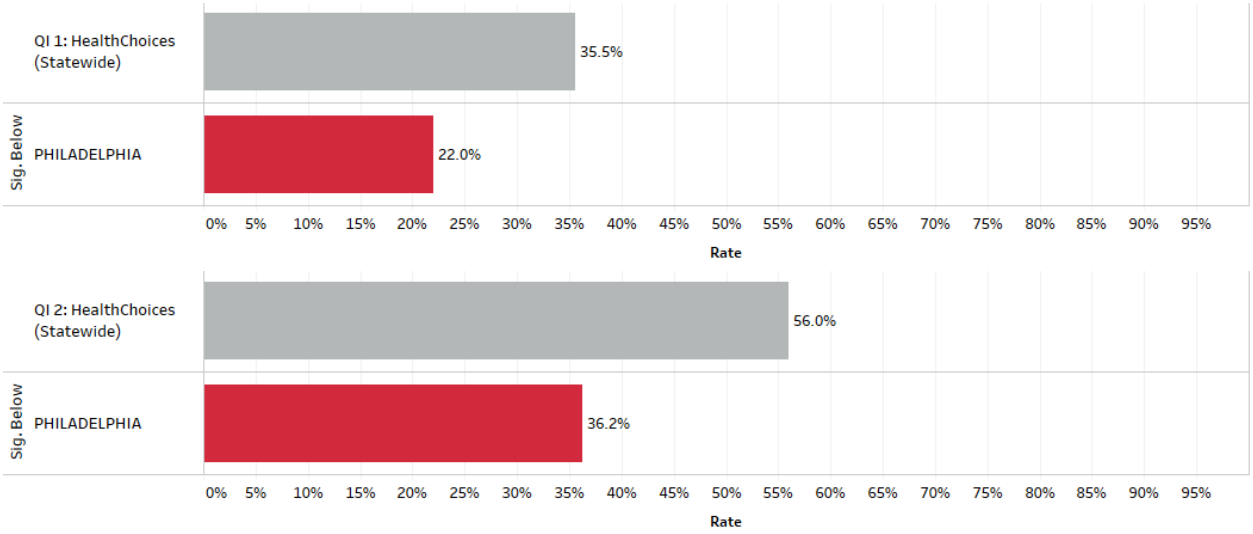

Figure 3.2: CBH Contractor MY 2018 HEDIS FUH Follow-up Rates (18–64 Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (18-64 Years).

(b) Overall Population: 6+ Years Old

The MY 2018 HealthChoices Aggregate HEDIS follow-up rates were 39.4% for QI 1 compared to 39.1% in MY 2017 and 60.2% for QI 2 compared to 63.2% in MY 2017 (**Table 3.2**). For CBH/Philadelphia, the MY 2018 HEDIS rates were 26.1% for QI 1 compared to 30.4% in MY 2017 and 40.5% for QI 2 compared to 56.8% in MY 2017; both rates were statistically significantly lower than the corresponding MY 2017 rates by 4.3 percentage points for QI 1 and 11.1 percentage points for QI 2.

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

MY 2018						MY 2017 %	MY 2018 Rate Comparison		
				95% CI			To MY 2017		To HEDIS 2019 Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
QI1 – HEDIS 7-Day Follow-up (All Ages)									
HealthChoices (Statewide)	16,107	40,876	39.4%	38.9%	39.9%	39.1%	0.3	NO	Below 75th Percentile, Above 50th Percentile
CBH	1,935	7,406	26.1%	25.1%	27.1%	30.4%	-4.3	YES	Below 25th Percentile
Philadelphia	1,935	7,406	26.1%	25.1%	27.1%	30.4%	-4.3	YES	Below 25th Percentile
QI2 – HEDIS 30-Day Follow-up (All Ages)									
HealthChoices (Statewide)	24,587	40,876	60.2%	59.7%	60.6%	63.2%	-2.6	Yes	Below 75th percentile, above 50th percentile
CBH	2,997	7,406	40.5%	39.3%	41.6%	56.8%	-11.1	Yes	Below 25th percentile
Philadelphia	2,997	7,406	40.5%	39.3%	41.6%	56.8%	-11.1	Yes	Below 25th percentile

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator: PPD; percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

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

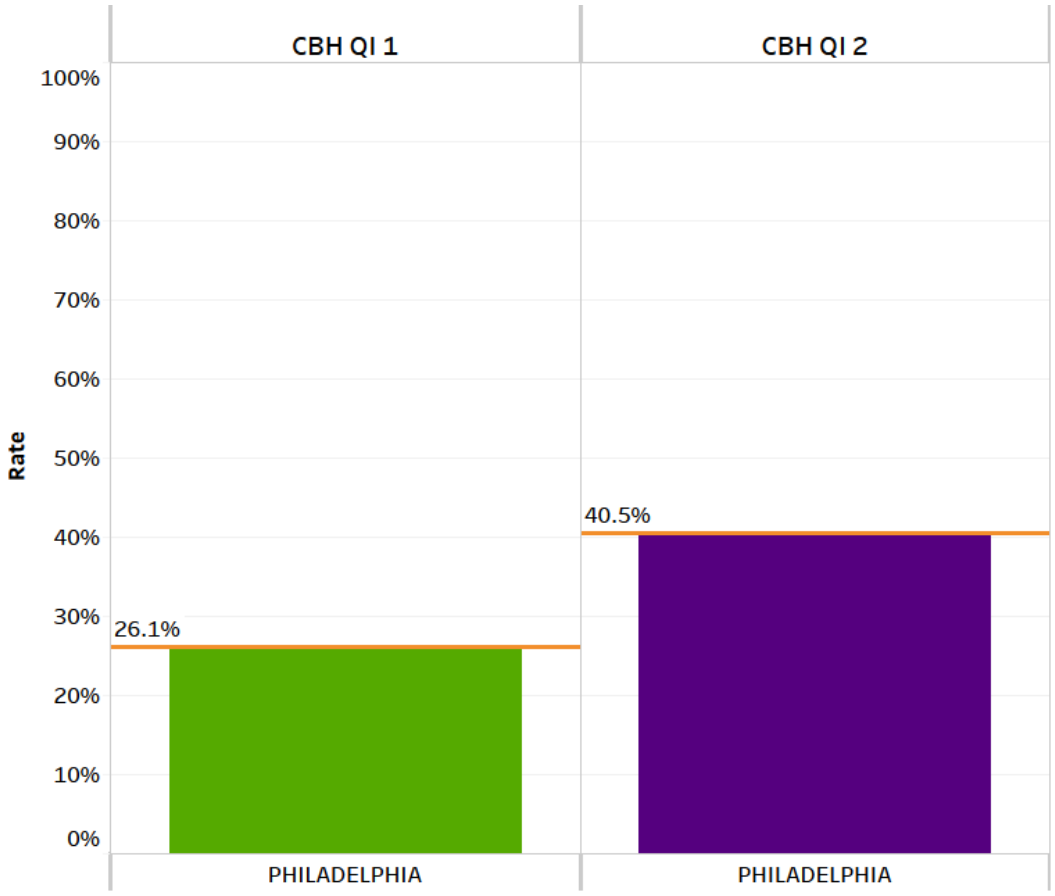

Figure 3.3: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (All Ages).

Figure 3.4 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The QI 1 rate for Philadelphia was statistically significantly below the MY 2017 QI 1 HealthChoices (Statewide) rate of 39.4% by 13.3 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 60.2% by 19.7 percentage points.

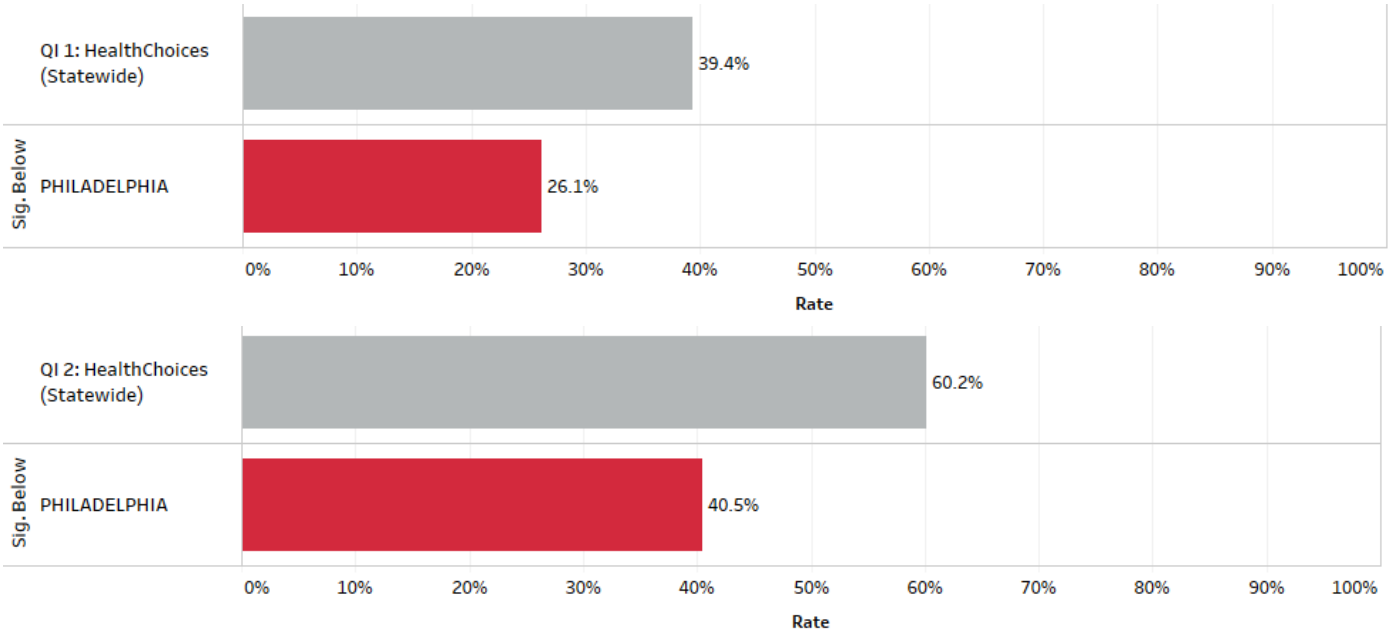

Figure 3.4: CBH MY 2017 HEDIS FUH Follow-up Rates (All Ages) that are Significantly Different than HealthChoices (Statewide) MY 2017 HEDIS FUH Follow-up Rates (All Ages).

(c) Age Group: 6–17 Years Old

The MY 2018 HealthChoices Aggregate rates in the 6 to 17 year age group were 51.5% for QI 1 compared to 55.1% in MY 2017 and 67.4% for QI 2 compared to 78.7% in MY 2017 (**Table 3.3**). The CBH MY 2018 HEDIS follow-up rates for members ages 6 to 17 were 51.5% for QI 1 compared to 54.5% in MY 2017 and 67.4% for QI 2 compared to 73.0% in MY 2017. Both QI1 and QI2 rates were statistically significantly lower than CBH's MY 2017 rates.

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

MY 2017						MY 2017	MY 2018 Rate Comparison To MY 2017	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI1 – HEDIS 7-Day Follow-up (6-17 Years)								
HealthChoices (Statewide)	4,592	8,243	55.7%	54.6%	56.8%	55.1%	0.6	NO
CBH	566	1,100	51.5%	48.5%	54.5%	56.0%	-4.6	YES
Philadelphia	566	1,100	51.5%	48.5%	54.5%	56.0%	-4.6	YES
QI2 – HEDIS 30-Day Follow-up (6-17 Years)								
HealthChoices (Statewide)	6,406	8,243	77.7%	76.8%	78.6%	78.7%	-0.9	NO
CBH	741	1,100	67.4%	64.5%	70.2%	73.0%	-5.6	YES
Philadelphia	741	1,100	67.4%	64.5%	70.2%	73.0%	-5.6	YES

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: Percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

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

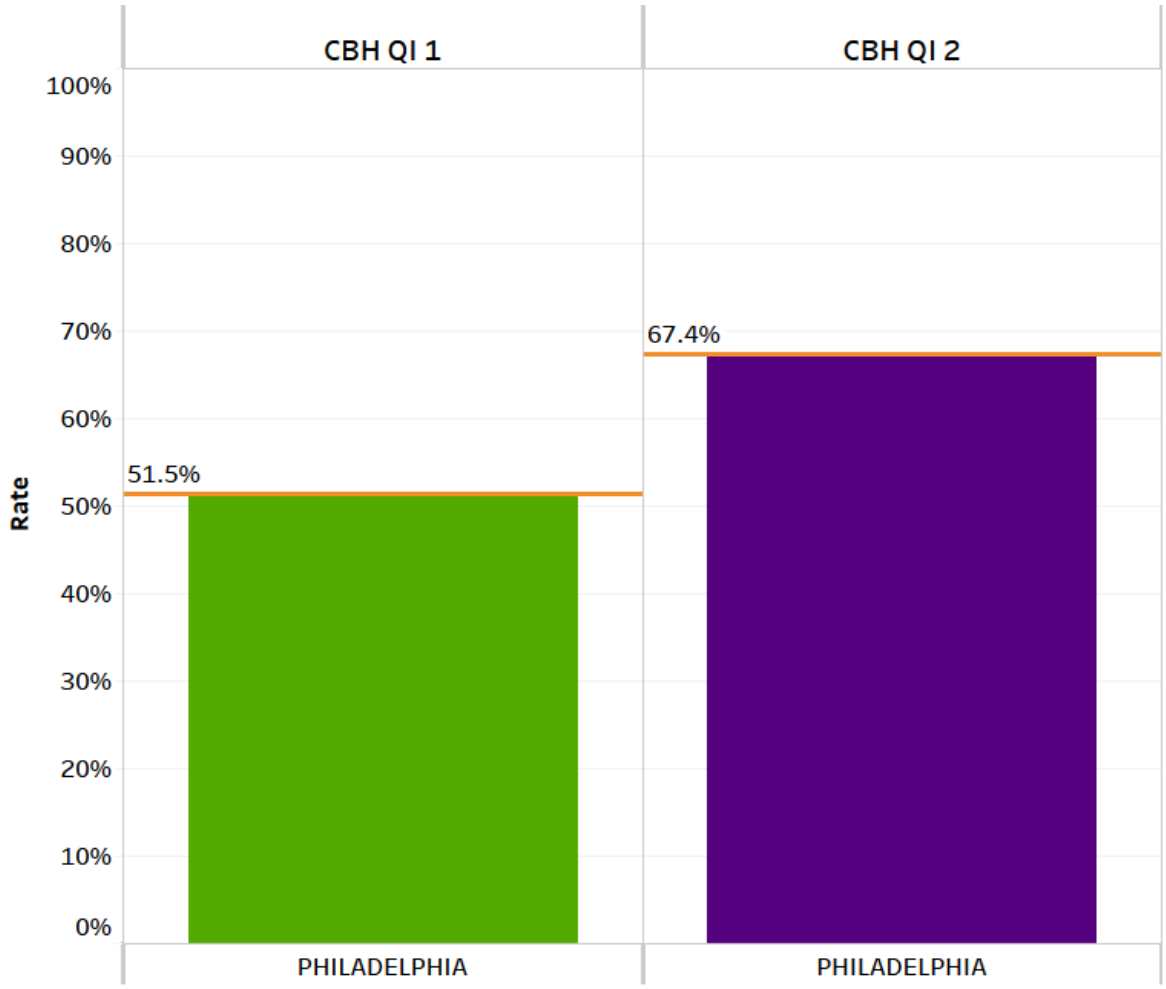

Figure 3.5: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (6-17 Years).

Figure 3.6 shows that the QI 1 follow-up rates for Philadelphia were statistically significantly below the QI 1 HealthChoices (Statewide) rate of 55.7% by 4.2 percentage points. The QI 2 rate for Philadelphia was statistically significantly lower than the QI 2 HealthChoices (Statewide) rate of 77.7% by 10.3 percentage points.

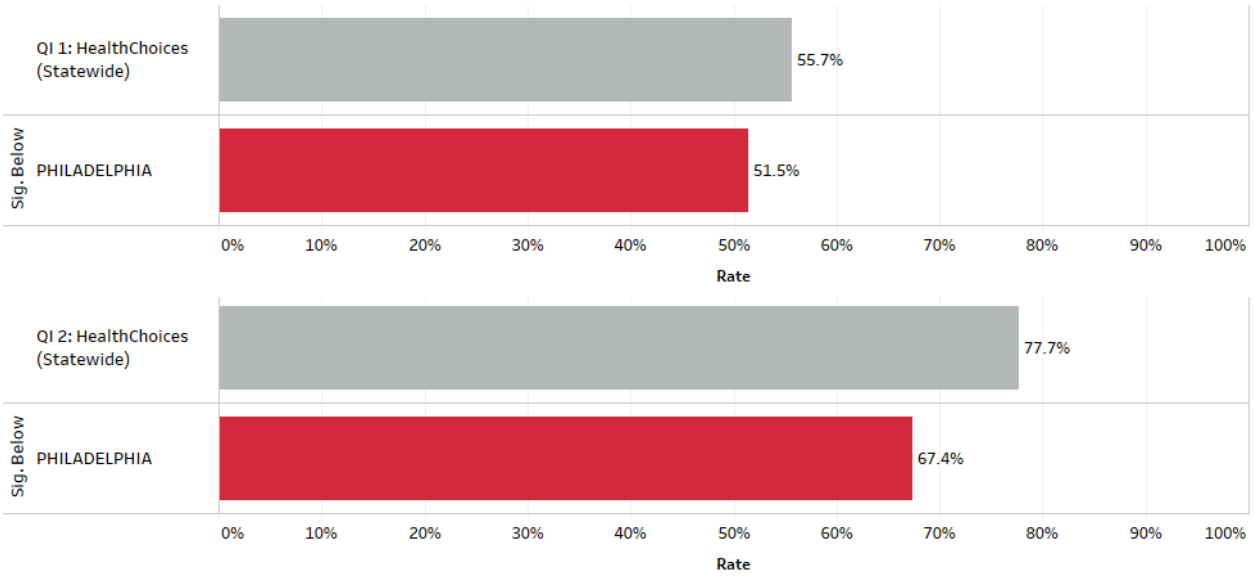

Figure 3.6: CBH MY 2018 HEDIS FUH Follow-up Rates (6-17 Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (6-17 Years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

The MY 2018 HealthChoices Aggregate rates were 53.1% for QI A compared to 52.2% in MY 2017 and 69.6% for QI B compared to 69.6% in MY 2017 (**Table 3.4**). There was a statistically significant increase from the MY 2017 PA-specific follow-up rates by 0.9 percentage points for QI A. The CBH MY 2018 PA-specific follow-up rates were 47.7% for QI A compared to 49.5% in MY 2017 and 61.4% for QI B compared to 63.4% in MY 2017 with a statistically significant decrease in the year-to-year rate difference for both QI A and QI B, 1.8 and 2.0 respectively.

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

MY 2018						MY 2017	MY 2018 Rate Comparison To MY 2017	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-up (All Ages)								
HealthChoices (Statewide)	21,746	40,979	53.1%	52.6%	53.6%	52.2%	0.9	YES
CBH	3,568	7,476	47.7%	46.6%	48.9%	49.5%	-1.8	YES
Philadelphia	3,568	7,476	47.7%	46.6%	48.9%	49.5%	-1.8	YES
QI B – PA-Specific 30-Day Follow-up (All Ages)								
HealthChoices (Statewide)	28,504	40,979	69.6%	69.1%	70.0%	69.6%	-0.1	NO
CBH	4,588	7,476	61.4%	60.3%	62.5%	63.4%	-2.0	YES
Philadelphia	4,588	7,476	61.4%	60.3%	62.5%	63.4%	-2.0	YES

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

Figure 3.7 is a graphical representation of the MY 2018 PA-Specific follow-up rates in the overall population for CBH and its associated HC BH Contractor. The orange line represents the MCO average.

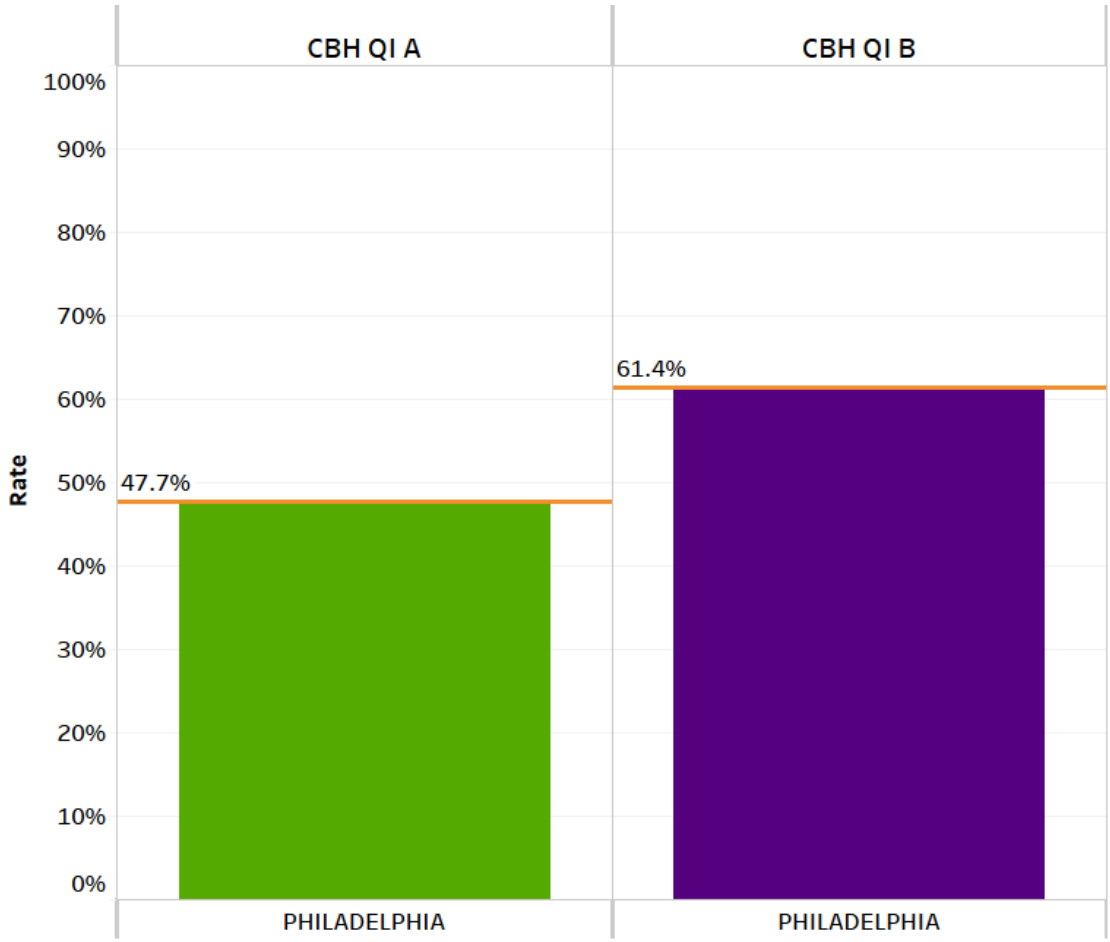

Figure 3.7: MY 2018 PA-Specific FUH 7- and 30-Day Follow-up Rates (All Ages).

Figure 3.8 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The QI A rate for Philadelphia was statistically significantly lower than the QI A HC BH (Statewide) rate of 53.1% by 5.4 percentage points, and the QI B rate for Philadelphia was statistically significantly lower than the QI B HC BH (Statewide) rate of 69.6% by 8.2 percentage points.

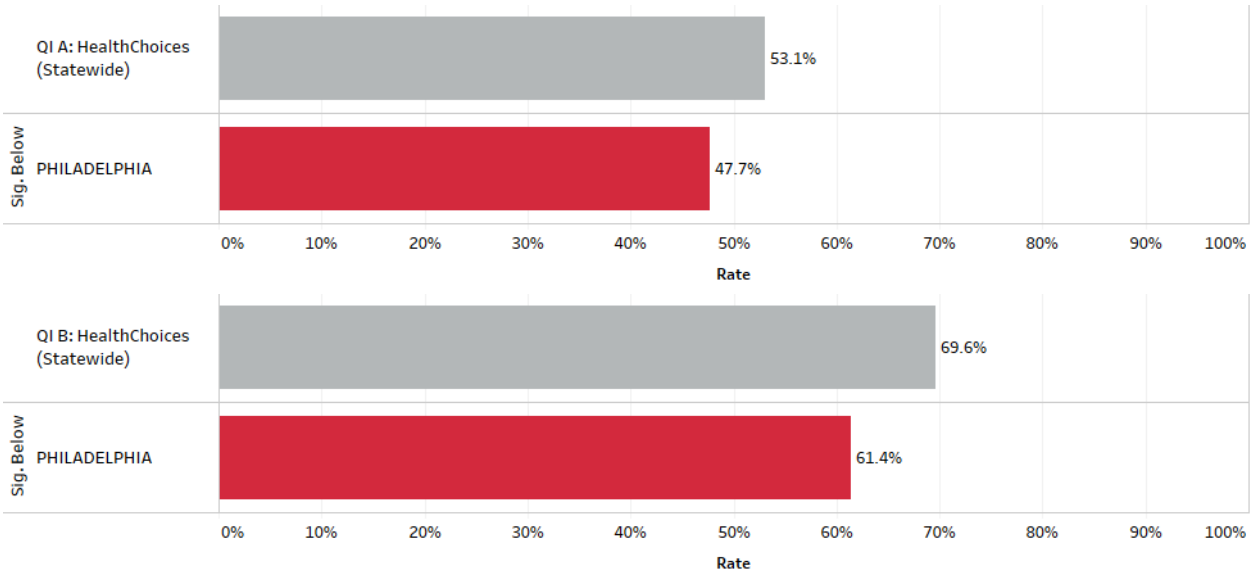

Figure 3.8: CBH MY 2018 PA-Specific FUH Follow-up Rates (All Ages) that are Significantly Different than HealthChoices (Statewide) MY 2018 PA-Specific FUH Follow-up Rates (All Ages).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS 2019 specifications, including revision of the denominator to include members with a principal diagnosis of intentional self-harm. That said, efforts should continue to be made to improve Follow-up After Hospitalization for Mental Illness performance, particularly for those BH-MCOs that performed below the HealthChoices Statewide rate. Following are recommendations that are informed by the MY 2018 review:

- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2018, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health care follow-up. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable HC BH Contractor exceptions, FUH rates have, for the most part decreased (worsened) for the BH-MCO. In some cases, the change was a continuation or even acceleration of existing trends. As previously noted, this analysis was not able to carry out more detailed examination of rates associated with the Medicaid expansion subpopulation. The potential impact on rates from the Medicaid expansion in 2018 were not evaluated in this report, although comparisons to the non-Medicaid population were carried out in a separate 2019 (MY 2018) FUH "Rates Report" produced by the EQRO and which, for the first time this year, is being made available to BH MCOs in an interactive Tableau® workbook. BH-MCOs and HC BH Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For one, it is important for BH-MCOs and HC BH Contractors to analyze performance

rates by racial and ethnic categories and to target the demographic populations that do not perform as well as their counterparts. The BH-MCOs and HC BH Contractors should continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance. The aforementioned 2019 (MY 2018) FUH Rates Report is one source BH MCOs can use to investigate potential health disparities in FUH.

- BH-MCOs and HC BH Contractors are encouraged to review the 2019 (MY 2018) FUH Rates Report in conjunction with the corresponding 2019 (MY 2018) inpatient psychiatric readmission Rates (REA) Report. The BH-MCOs and HC BH contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, and then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2018 study conducted in 2019 was the tenth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2018. This measure continued to be of interest to OMHSAS for the purposes of comparing HC BH Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

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

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

Eligible Population

The entire eligible population was used for all 67 counties and 29 HC BH Contractors participating in the MY 2018 study. Eligible cases were defined as those members in the HealthChoices Behavioral Health Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2018;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event;
- The claim was clearly identified as a discharge.

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

Methodology

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

Performance Goals

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

Findings

BH-MCO and HC BH Contractor Results

The results are presented at the BH-MCO and then HC BH Contractor level. Year-to-year comparisons of MY 2018 to MY 2017 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the *Z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the Percentage Point Difference (PPD) between the rates.

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

Lastly, aggregate rates were compared to the OMHSAS-designated performance measure goal of 10.0%. Individual BH-MCO and HC BH Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the performance measure goal.

The MY 2017 HealthChoices Aggregate (Statewide) readmission rate was 13.7%, which represents an increase from the MY 2017 HealthChoices Aggregate rate of 13.4% by 0.3 percentage points (**Table 3.5**); this difference was not statistically significant. The CBH/Philadelphia County MY 2017 rate of 13.3% was not statistically significantly different from the MY 2017 rate of 12.9%.

Table 3.5: MY 2018 REA Readmission Indicators

	MY 2018							MY 2018 Rate Comparison To MY 2017	
				95% CI					
Measure	(N)	(D)	%	Lower	Upper	Goal Met?	MY 2017 %	PPD	SSD
Inpatient Readmission									
HealthChoices (Statewide)	7,188	52,290	13.7%	13.5%	14.0%	No	13.4%	0.3	NO
CBH	1,278	9,589	13.3%	12.6%	14.0%	No	12.9%	0.4	NO
Philadelphia	1,278	9,589	13.3%	12.6%	14.0%	No	12.9%	0.4	NO

* The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.
Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
MY: measurement year; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; CBH: Community Behavioral Health.

Figure 3.9 is a graphical representation of the MY 2018 readmission rates for CBH and its associated HC BH Contractor. The orange line represents the MCO average. CBH and Philadelphia County did not meet the performance goal of a readmission rate below 10.0% in MY 2018.

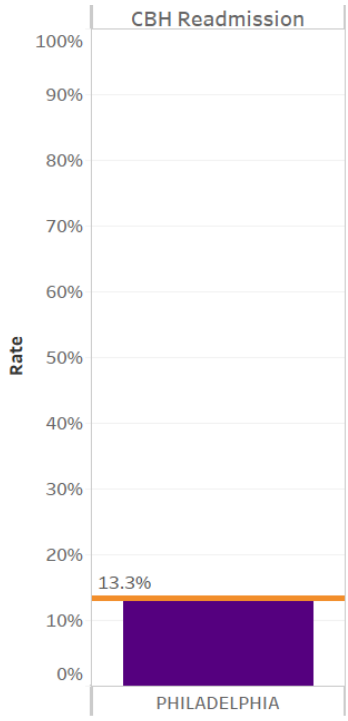

Figure 3.9: MY 2018 REA Readmission Rates for CBH.

Figure 3.10 shows that the Philadelphia County rate of 13.3% was not statistically significantly different from the HC BH (Statewide) rate of 13.7%.

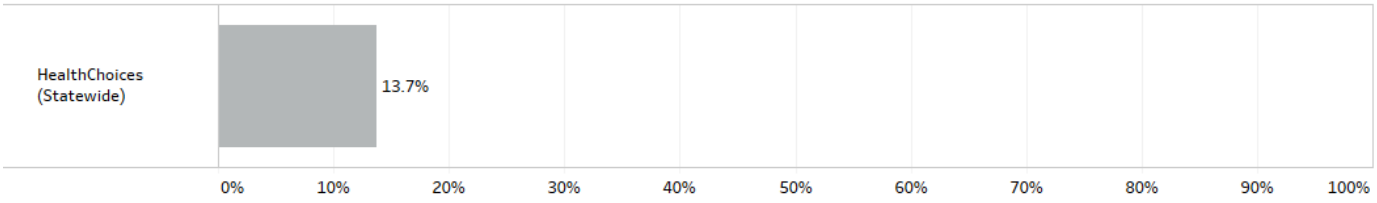

Figure 3.10: CBH MY 2018 REA Readmission Rates (All Ages) that are Significantly Different than HealthChoices (Statewide) MY 2018 REA Readmission Rates (All Ages).

Conclusion and Recommendations

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

Despite a number of years of data collection and interventions, readmission rates after psychiatric discharge have, for the most part, not improved and, for some BH-MCOs and their Contractors, rates have worsened (increased). Readmission for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS. As a result, many recommendations previously made remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the past performance improvement project cycle, the recommendations may assist in future discussions.

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

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

As part of the CMS's Adult Quality Measure Grant Program, the DHS was required to report the Initiation and Engagement of Alcohol and Other Drug Dependence (IET) measure. Although the grant ended in December 2014, DHS will continue reporting the IET measure as part of CMS's Adult Quality Core Measure set. This measure was reported initially by one county for MY 2012 and expanded to the HealthChoices population in MY 2013. Due to several implementation issues identified with BH-MCO access to all applicable data and at DHS's request, this measure was produced by IPRO. IPRO began development of this measure in 2014 for MY 2013 and continued to produce the measure in 2017 and 2018. The measure was produced according to HEDIS 2019 specifications. The data source was encounter data submitted to DHS by the BH-MCOs and the Physical Health MCOs (PH-MCOs). As directed by OMHSAS, IPRO produced rates for this measure for the HealthChoices population, by BH-MCO, and by HC BH Contractor.

This study examined substance abuse services provided to members participating in the HealthChoices Behavioral Health and Physical Health Programs. For the indicator, the criteria used to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. Date-of-service and diagnosis/procedure codes were used to identify the administrative numerator-positives. The denominator and numerator criteria were identical to the HEDIS 2019 specifications, with one modification: members must be enrolled in the same PH-MCO and BH-MCO during the continuous enrollment period (from 60 days prior to the index event, to 48 days after the index event). This

performance measure assessed the percentage of members who had a qualifying encounter with a diagnosis of alcohol or other drug dependence (AOD) who had an initiation visit within 14 days of the initial encounter, and the percentage of members who also had at least two visits within 34 days after the initiation visit.

Quality Indicator Significance

Substance abuse is a major health issue in the United States. According to the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 8.5% of adults had an alcohol use disorder problem, 2% met the criteria for a drug use disorder, and 1.1% met the criteria for both (U.S. Department of Health & Human Services, 2008). Research shows that people who are dependent on alcohol are much more likely than the general population to use drugs, and vice versa. Patients with co-occurring alcohol and other drug use disorders are more likely to have psychiatric disorders, such as personality, mood, and anxiety disorders, and they are also more likely to attempt suicide and to suffer health problems (Arnaout & Petrakis, 2008). The opioid crisis has only added to the urgency. Deaths from opioid overdoses alone reached 28,647 in 2014 (The Surgeon General's Report on Alcohol, Drugs, and Health, 2016).

With appropriate intervention for AOD dependence, the physical and behavioral health conditions of patients can be improved and the use of health care services, such as the emergency departments (ED), will be decreased. In 2009 alone, there were nearly 4.6 million drug-related ED visits nationwide (National Institute on Drug Abuse, 2011). Social determinants of health are also themselves impacted by AOD. Improvement in the socioeconomic situation of patients and lower crime rates will likely follow if suitable treatments are implemented.

Eligible Population[2]

The entire eligible population was used for all 29 HC BH Contractors participating in the MY 2018 study. Eligible cases were defined as those members in the HealthChoices Behavioral Health and Physical Health Programs who met the following criteria:

- Members who had an encounter with a primary or secondary AOD diagnosis between January 1 and November 15, 2018;
- Continuously enrolled in both HealthChoices Behavioral Health and Physical Health from 60 days prior to the AOD diagnosis to 48 days after the AOD diagnosis with no gaps in enrollment;
- No encounters with an AOD diagnosis in the 60 days prior to the initial encounter;
- If a member has multiple encounters in the measurement year that meet the criteria, only the first encounter is used in the measure.

This measure is reported for three age cohorts: ages 13 to 17 years, ages 18+ years, and ages 13+ years.

Numerators

This measure has two numerators:

Numerator 1 – Initiation of AOD Treatment: Members who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization with a primary or secondary AOD diagnosis within 14 days of the diagnosis.

Numerator 2 – Engagement of AOD Treatment: Members who initiated treatment and who had two or more additional inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with a primary or secondary diagnosis of AOD within 34 days of the initiation visit. The engagement numerator was only evaluated for members who passed the initiation numerator.

Methodology

Because this measure requires the use of both physical health and behavioral health encounters, only members who were enrolled in both HealthChoices Behavioral Health and Physical Health Programs were included in this measure. The source for all information was administrative data provided to IPRO by the BH-MCOs and PH-MCOs. The source for all administrative data was the MCOs' transactional claims systems. Because administrative data from multiple sources

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

were needed to produce this measure, the measure was programmed and reported by IPRO. The results of the measure were presented to representatives of each BH-MCO, and the BH-MCOs were given an opportunity to respond to the results of the measure.

Limitations

Because physical health encounters with an AOD diagnosis are used in this measure, a BH-MCO does not have complete information on all encounters used in this measure. This incomplete information will limit the BH-MCOs' ability to independently calculate their performance of this measure and determine the effectiveness of interventions.

Findings

BH-MCO and HC BH Contractor Results

The results are presented at the BH-MCO and HC BH Contractor level when multiple HC BH Contractors are represented by a single BH-MCO. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (i.e., across HC BH Contractors with the same contracted BH-MCO). The HC BH Contractor-specific rates were calculated using the numerator and denominator for that particular HC BH Contractor. For each of these rates, the 95% CI was reported. The HealthChoices BH Statewide rate was also calculated for this measure for each age group.

BH-MCO-specific rates were compared to the HealthChoices Statewide rate to determine if they were statistically significantly above or below that value. Statistically significant differences in BH-MCO rates are noted.

HC BH Contractor-specific rates were compared to the HealthChoices BH Statewide rate to determine if they were statistically significantly above or below that value. Statistically significant differences in HC BH Contractor-rates are noted.

The performance measure results for the three age cohorts (13 to 17 years old, ages 18+ years, and ages 13+ years) are compared to HEDIS national percentiles. NCQA produces annual HEDIS IET benchmarks for these three age bands; therefore, results for each age group are compared to national percentiles for the corresponding age bands.

(a) Age Group: 13–17 Years Old

The MY 2018 HealthChoices Aggregate (Statewide) rates in the 13–17 years age group were 44.7% for Initiation and 31.8% for Engagement (**Table 3.6**). These rates were statistically significantly lower compared to the MY 2017 13–17 years age group HealthChoices Aggregate rates of 46.3% and 34.6%, respectively. In MY 2018, the HealthChoices Aggregate rate for Initiation was between the HEDIS percentiles for the 50th and 75th percentiles, while the HealthChoices Aggregate rate for Engagement was at or above the 75th percentile. The CBH MY 2018 13–17 years age group Initiation rate was 57.3%, which was not statistically significantly different from the MY 2017 CBH rate. Similarly, the CBH MY 2018 13–17 years age group Engagement rate was 39.7%, which also was not statistically significantly different from the MY 2017 rate. CBH's Initiation and Engagement rates for MY 2017 were at or above the 75th percentiles.

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

MY 2018							MY 2018 Rate Comparison		
				95% CI		MY 2017 %	To MY 2017		To HEDIS 2019 Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
Numerator 1: Initiation of AOD Treatment (13–17) Years									
HealthChoices (Statewide)	1,204	2,692	44.7%	42.8%	46.6%	46.3%	-1.6	NO	Below 75th Percentile, Above 50th Percentile
CBH	280	489	57.3%	52.8%	61.7%	55.3%	2.0	NO	At or Above 75th Percentile
Philadelphia	280	489	57.3%	52.8%	61.7%	55.3%	2.0	NO	At or Above 75th Percentile
Numerator 2: Engagement of AOD Treatment (13–17) Years									
HealthChoices (Statewide)	855	2692	31.8%	30.0%	33.5%	34.6%	-2.9	YES	At or Above 75th Percentile
CBH	194	489	39.7%	35.2%	44.1%	38.6%	1.1	NO	At or Above 75th Percentile
Philadelphia	194	489	39.7%	35.2%	44.1%	38.6%	1.1	NO	At or Above 75th Percentile

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

Figure 3.11 is a graphical representation of the MY 2018 HEDIS follow-up rates in the 13–17 years age population for CBH and its associated HC BH Contractor. The orange line represents the MCO average.

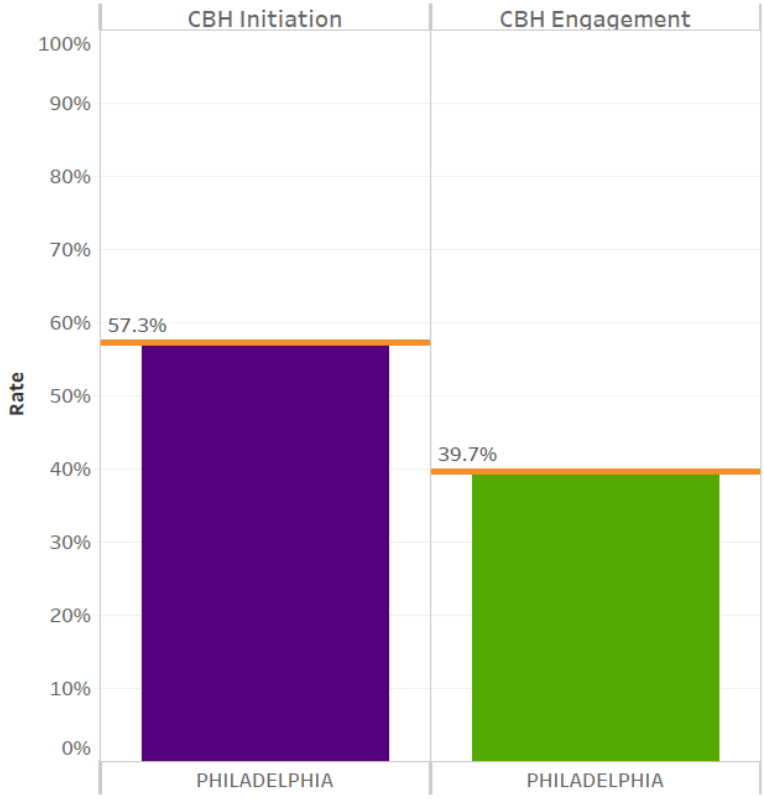

Figure 3.11: MY 2018 IET Initiation and Engagement Rates (13–17 Years).

Figure 3.12 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. For both IET rates, Philadelphia County was statistically significantly above the HC BH (Statewide) rate of 44.7% for Initiation by 12.6 percentage points. Philadelphia's engagement rate was 39.7%, 7.9 percentage points above the HC BH (Statewide) rate.

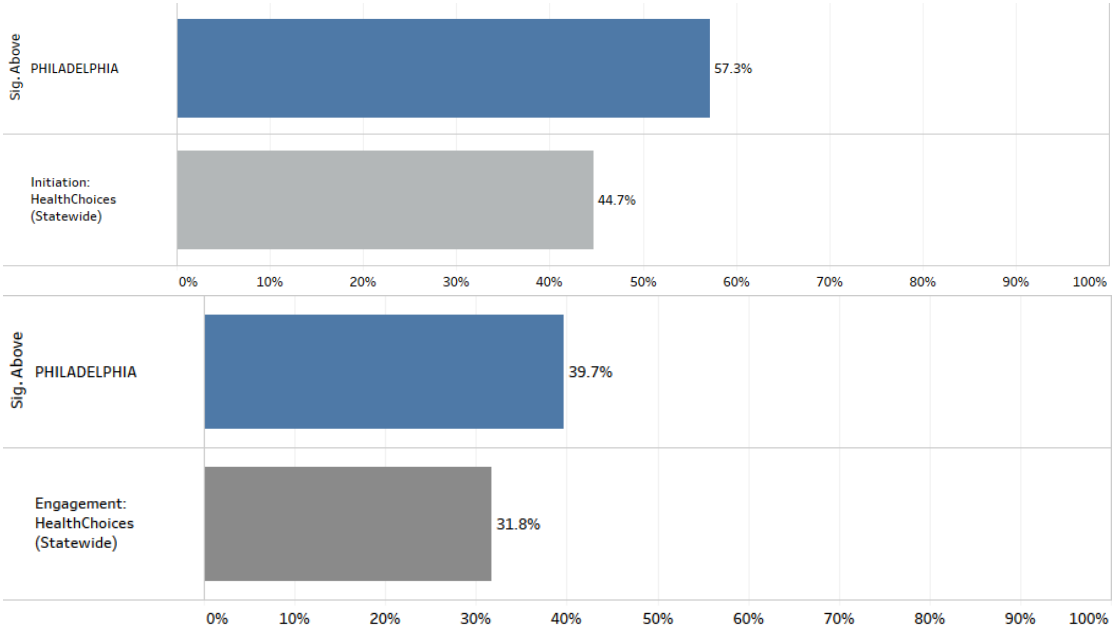

Figure 3.12: CBH MY 2018 IET Rates (13–17 Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 IET Rates (13–17 Years).

(b) Age Group: 18+ Years Old

The MY 2018 HealthChoices Aggregate rates in the 18+ years age group were 41.9% for Initiation and 28.3% for Engagement (**Table 3.7**). The HealthChoices Aggregate Initiation rate increased by 0.8 percentage points and the Engagement rate decreased by 5.3 percentage points from the prior year. The MY 2018 HealthChoices Aggregate Initiation rate in this age cohort was above the HEDIS 2018 25th percentile and below 50th percentile, while the Engagement rate was at or above 75th percentiles. The CBH MY 2018 Initiation rate for the 18+ years population was 39.5%, which was above the HEDIS 2018 25th percentile and below the 50th percentile. CBH's MY 2018 rate increased significantly from MY 2017 rate by 3.5 percentage points. The CBH MY 2017 Engagement rate for this age cohort was 23.6%, which was at or above the HEDIS 2018 75th percentile. The CBH Engagement rate for this age group was statistically significantly lower than the MY 2017 rate of 28.5% by 4.9 percentage points.

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

MY 2018							MY 2018 Rate Comparison		
				95% CI		MY 2017 %	To MY 2017		To HEDIS 2019 Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
Numerator 1: Initiation of AOD Treatment (18+ Years)									
HealthChoices (Statewide)	24,954	59,586	41.9%	41.5%	42.3%	41.1%	0.8	YES	Below 50th Percentile, Above 25th Percentile
CBH	5,794	14,664	39.5%	38.7%	40.3%	36.0%	3.5	YES	Below 50th Percentile, Above 25th Percentile
Philadelphia	5,794	14,664	39.5%	38.7%	40.3%	36.0%	3.5	YES	Below 50th Percentile, Above 25th Percentile
Numerator 2: Engagement of AOD Treatment (18+ Years)									
HealthChoices (Statewide)	16,886	59,586	28.3%	28.0%	28.7%	33.7%	-5.3	YES	At or Above 75th Percentile
CBH	3,458	14,664	23.6%	22.9%	24.3%	28.5%	-4.9	YES	At or Above 75th Percentile
Philadelphia	3,458	14,664	23.6%	22.9%	24.3%	28.5%	-4.9	YES	At or Above 75th Percentile

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

Figure 3.13 is a graphical representation of the 18+ years age group MY 2018 HEDIS Initiation and Engagement rates for CBH and its associated HC BH Contractor. The orange line represents the MCO average.

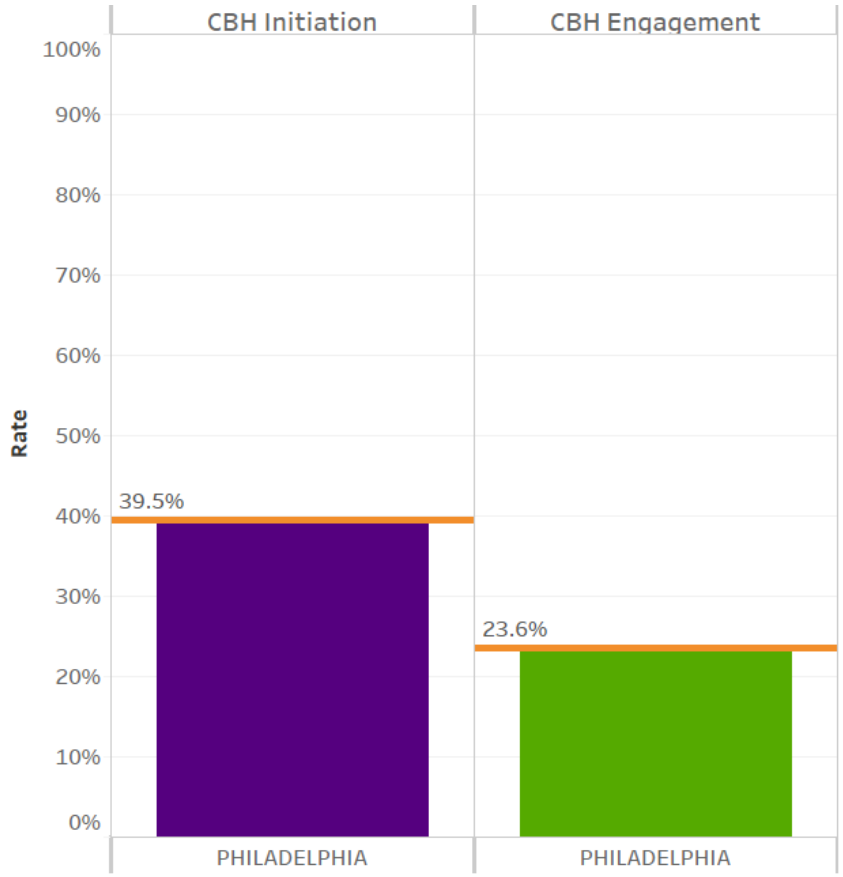

Figure 3.13: MY 2017 IET Initiation and Engagement Rates (18+ Years).

Figure 3.14 is a graphical representation of the MY 2018 HEDIS follow-up rates in the 18+ years age group population for CBH and its associated HC BH Contractor. For both rates, Philadelphia County was statistically significantly below the HC BH (Statewide) rate of 41.9% for Initiation and 28.3% for Engagement by 2.4 and 4.7 percentage points, respectively.

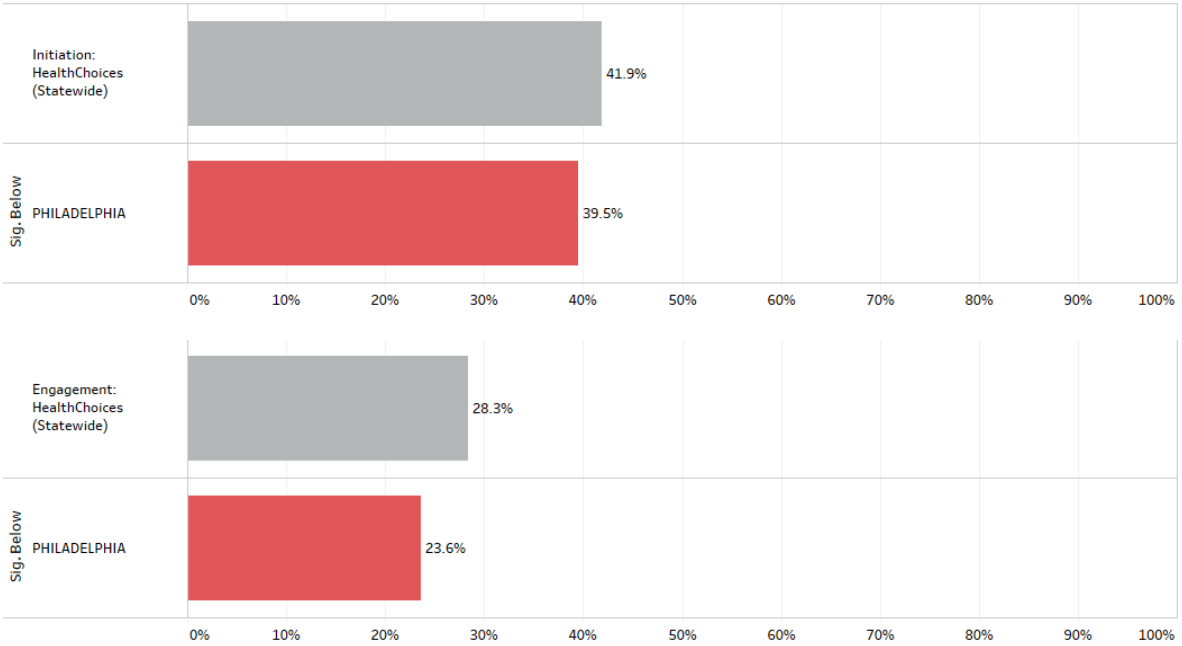

Figure 3.14: CBH Contractor MY 2018 IET Rates (18+ Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 IET Rates (18+ Years).

(c) Age Group: 13+ Years Old (All Ages)

The MY 2018 HealthChoices Aggregate rates in the 13+ years age group were 42.0% for Initiation and 28.5% for Engagement (**Table 3.8**). The Initiation rate was statistically significantly higher than the MY 2017 Initiation rate by 0.7 percentage points, and the Engagement rate was statistically significantly lower than the MY 2017 Engagement rate by 5.2 percentage points. The MY 2018 HealthChoices Aggregate Initiation rate was above the HEDIS 2018 25th percentile and below the 50th percentile, while the Engagement rate was at or above the 75th percentile. The CBH MY 2018 Initiation rate for the 13+ years age population was 40.1%, which was above the HEDIS 2019 25th percentile and below the HEDIS 2019 50th percentile. The CBH MY 2018 Engagement rate was 24.1%, and was at or above the HEDIS 75th percentile. For CBH, both its Initiation and its Engagement rates were statistically significantly lower than their corresponding MY 2017 rates.

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

MY 2018							MY 2018 Rate Comparison		
				95% CI		MY 2017 %	To MY 2017		To HEDIS 2019 Percentiles
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	
Numerator 1: Initiation of AOD Treatment (All Ages)									
HealthChoices (Statewide)	26,158	62,278	42.0%	41.6%	42.4%	41.3%	0.7	YES	Below 50th Percentile, Above 25th Percentile
CBH	6,074	15,153	40.1%	39.3%	40.9%	36.7%	3.4	YES	Below 50th Percentile, Above 25th Percentile
Philadelphia	6,074	15,153	40.1%	39.3%	40.9%	36.7%	3.4	YES	Below 50th Percentile, Above 25th Percentile
Numerator 2: Engagement of AOD Treatment (All Ages)									
HealthChoices (Statewide)	17,741	62,278	28.5%	28.1%	28.8%	33.7%	-5.2	YES	At or Above 75th Percentile
CBH	3,652	15,153	24.1%	23.4%	24.8%	28.8%	-4.7	YES	At or Above 75th Percentile
Philadelphia	3,652	15,153	24.1%	23.4%	24.8%	28.8%	-4.7	YES	At or Above 75th Percentile

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

Figure 3.15 is a graphical representation of the MY 2018 HEDIS follow-up rates in the overall population for CBH and its associated HC BH Contractor. The orange line represents the MCO average.

Figure 3.15: MY 2017 IET Initiation and Engagement Rates (All Ages).

Figure 3.16 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide benchmark. The rates for Philadelphia County were statistically significantly lower than the HC Statewide rate for Initiation (by 1.9 percentage points) and Engagement (by 4.4 percentage points).

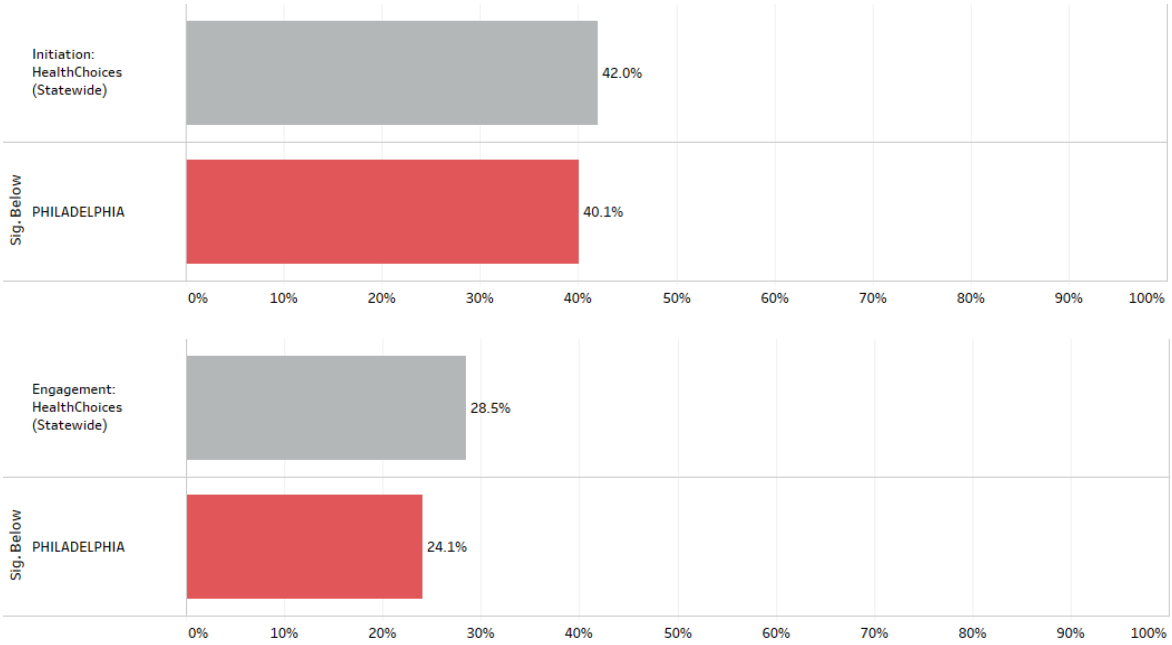

Figure 3.16: CBH MY 2018 IET Rates (All Ages) that are Significantly Different than HealthChoices (Statewide) MY 2018 IET Rates (All Ages).

Conclusion and Recommendations

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

- The IET measure is a key performance indicator of the Integrated Care Program (ICP) in Pennsylvania; this program seeks to promote better data-sharing and coordination between the physical heath and behavioral health care systems in the PA HealthChoices Medicaid Managed Care program. BH-MCOs should continue to find ways to build and capitalize on partnerships with the PH-MCOs serving the same members. To this end, OMHSAS, in conjunction with its sister agency, the Office of Medical Assistance Programs (OMAP), has begun to drill into the ICP measure data, including IET, to determine the relative performance of those partnerships and to better understand the strategies that seem to be generating better performance.
- BH-MCOs should further develop programs to report this measure for their population on a regular basis using information gained from the 2019 (MY 2018) IET Rates Report which is now available as an interactive Tableau workbook. This information will allow BH-MCOs to identify specific subpopulations with low performance for future interventions.
- BH-MCOs should identify high-performing subpopulations to determine if any best practices exist for increasing the Initiation and Engagement rates.
- When developing reporting and analysis programs, CBH showed success in the 13-17 years old population and should focus on the Initiation rate in the 18+ population because it was below the 75th percentile for this measure.

IV: Quality Studies

The purpose of this section is to describe quality studies performed in 2018 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the Review Year (42 CFR 438.358 (c)(5)).

Certified Community Behavioral Health Clinics

On July 1, 2017, Pennsylvania launched its SAMHSA-funded Certified Community Behavioral Health Clinics (CCBHCs) Demonstration Project ("Demonstration"), to run through June 30, 2019. The results reported below are for Demonstration Year 1 (DY1) which ran from July 1, 2017 through June 30, 2018. The purpose of the Demonstration is to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, behavioral health screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services, along with outpatient clinic primary care screening and monitoring, are provided or managed directly by the CCBHCs. The other services, including targeted case management, peer support, psychiatric rehabilitation services and intensive community-based mental health care to members of the armed forces and veterans, may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of Evidence Based Practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Seven clinics were eventually certified and participated: Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA). In several cases, CCBHC-certified clinics shared agreements with one or more DCOs to supplement the core services provided at the clinic. The counties covered by these clinics span three BH-MCOs: CBH, CCBH, and MBH.

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

A second important feature of the Demonstration is an assessment, to be completed at its conclusion by the EQRO, to test whether the CCBHC clinics perform significantly better over the demonstration period compared to a control group of clinics located under the same HC BH contractors as the CCBHC clinics. Measurement of performance, in terms of both quality and overall cost, will span multiple areas and scales, involving a variety of administrative sources, medical records, and other sources. Several measures in the CCBHC measure set, including those reported directly by clinics (primarily medical record-based), are placed in a Quality Bonus Payment (QBP) program. Clinics performed a variety of activities in DY 1 to support these reporting objectives. Clinics collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collection of person-experience-of-care surveys for adults (PEC) as well as for children and youth (Y/FEC). Finally, clinics continued to collect and report on a quarterly basis, consumer-level files documenting various relevant characteristics of their CCBHC consumers, including housing, veteran, and insurance statuses. Throughout the process, OMHSAS and EQRO provided technical assistance focused on data collection, management, and reporting, where much of the focus was on operationalizing the quality and process measures using the clinics' data plans. In this respect, 2017 and early 2018 was a period of building up the capacity of the clinics to bring the vision of the CCBHC Demonstration to its full fruition. DY1 results, therefore, should be interpreted with caution to the extent that they cover a period in which clinics were still learning to fully implement their CCBHC quality and measurement programs.

Demonstration Year 1 Results

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

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

Table 4.1 CCBHC Quality Performance compared to Statewide and National Benchmarks

Measure	CCBHC weighted average	Comparison		
		State Weighted Average	National Average	Description (if National)
Follow-Up Care for Children Prescribed ADHD Medication - Initiation	78.7%		45.0%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up Care for Children Prescribed ADHD Medication - Continuation	88.1%		57.1%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 day	24.7%		10.4%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 day	36.8%		16.0%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Mental Illness - 7 day	51.4%		37.1%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Mental Illness - 30 day	62.2%		52.6%	HEDIS 2019 Quality Compass 50th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Initiation	15.7%	41.1%		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Engagement	4.3%	33.7%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 7 day	25.7%	34.7%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	27.1%	55.7%		

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

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

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

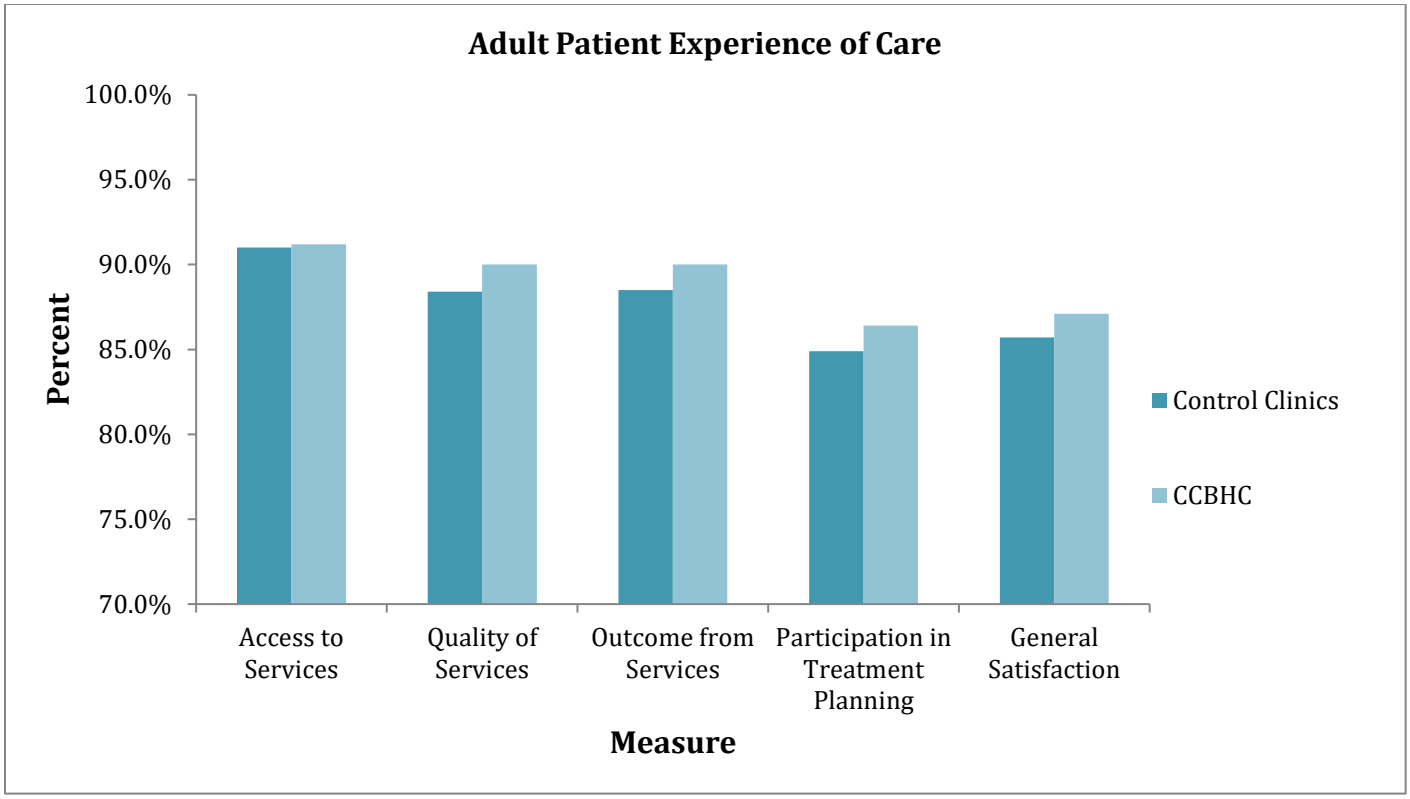

Figure 4.1 Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care

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

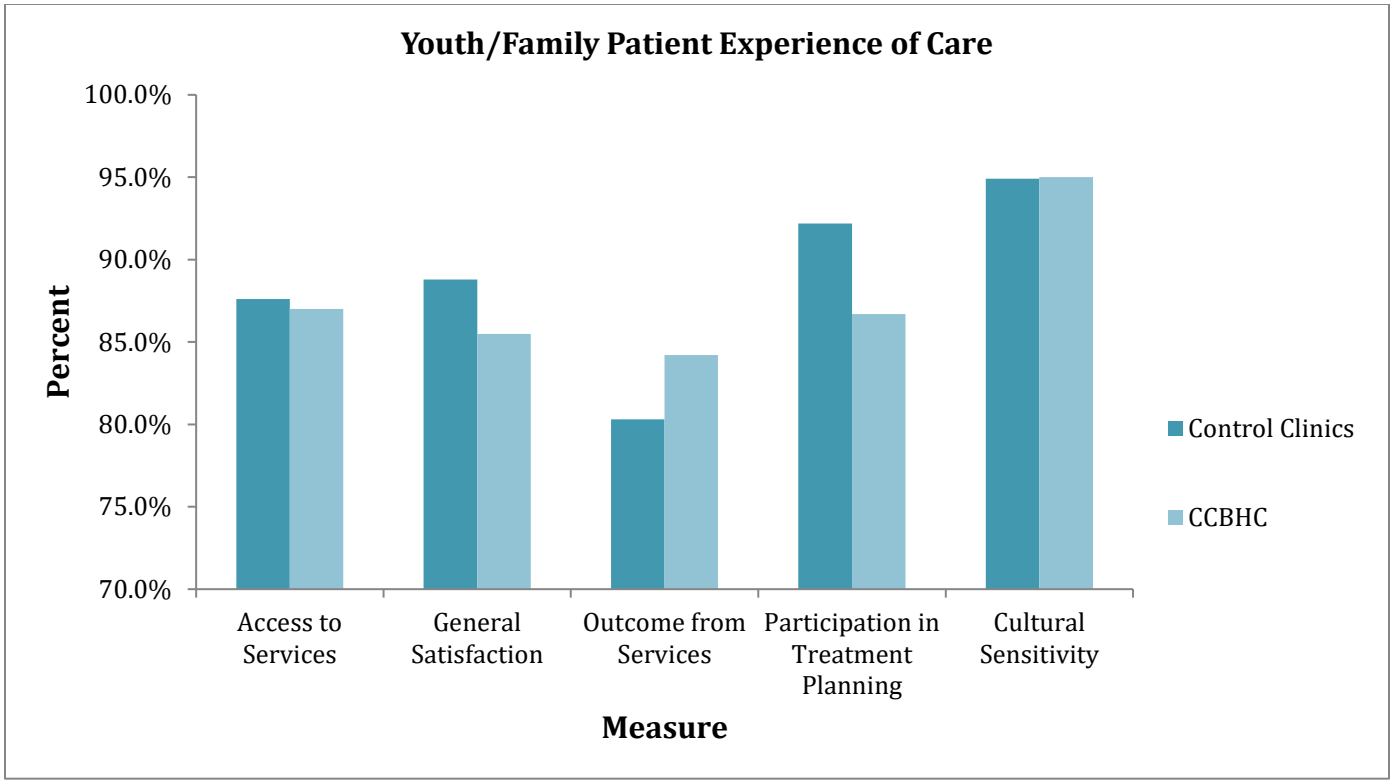

Figure 4.2 Comparison of CCBHC to Control Clinics on Child Patient Experience of Care

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

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

V: 2017 Opportunities for Improvement – MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH-MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2018 EQR Technical Reports. The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in June 2019. The 2019 EQR Technical Report is the 12th report to include descriptions of current and proposed interventions from each BH-MCO that address the prior year's deficiencies.

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

- follow-up actions that the BH-MCO has taken through June 30, 2019, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2019, as well as any additional relevant documentation provided by the BH-MCO.

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

Quality Improvement Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2017, CBH began to address opportunities for improvement related to compliance categories within the following Subparts: C (Enrollee Rights), D (Access to Care, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Practice Guidelines, and Quality Assessment and Performance Improvement Program), and F (Federal and State Grievance System Standards Regulations). The partially compliant categories within Subpart F were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by CBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring CBH into compliance with the relevant Standards. **Table 5.1** presents CBH's responses to opportunities for improvement cited by IPRO in the 2018 EQR Technical Report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.1: CBH Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found CBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CBH 2018.01	Within Subpart C: Enrollee Rights and Protections Regulations, CBH was partially compliant on one out of seven categories – Enrollee Rights.	Ongoing. New hires are trained at time of hire. Existing employees are trained annually.	The most recent training curricula for complains and grievances are attached. [Objects removed]
CBH 2018.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, CBH was partially compliant with five out of 10 categories and non-compliant with one out of 10 categories. The partially compliant categories were: **1) Availability of Services (Access to Care),** **2) Coverage and Authorization of Services,** **3) Provider Selection,** **4) Practice Guidelines,** **5) Quality Assessment and Performance Improvement Program.** The non-compliant category was: Coordination and Continuity of Care.	November 1, 2019	Bulletin requiring providers to inform CBH when they are not accepting new enrollees will be issued on November 1, 2019.
		October 26 & 31, 2018 November 2019	Denial Notice training for all clinical staff, including Physician Advisors and Psychologists was conducted in October 2018. [Objects removed] Next training will occur in November 2019.
		Monthly since March 2017	CBH conducts monthly denial notice audits. [Objects removed]
		June 3, 2019	A simplified word list to reduce use of medical jargon was distributed to all clinical staff. [Objects removed]
		March 1, 2019	The QM Work Plan has been updated to include corrective action items and performance improvement activities from previous findings. Additionally, the QM Work Plan and Program Description have been revised to align with OMHSAS's numbering of each standard. Both the 2019 Work Plan and Program Description were submitted to OMHSAS on March 1, 2019.
		April 30, 2019	The Annual Program Evaluation that includes a self assessment, an evaluation of our goals, and a description of the development of the following year's work plan was submitted to OMHSAS on April 30, 2019. An executive summary is available on our website for member and provider review. [Objects removed]

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found CBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
CBH 2018.03	Within Subpart F: Federal and State Grievance System Standards Regulations, CBH was partially compliant with eight 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) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.	February 2018	These are the documents that were submitted to OMHSAS on February 21, 2018 and are currently in use. [Objects removed]

Root Cause Analysis and Quality Improvement Plan

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

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

Following several years of underperformance in the key quality indicator areas, OMHSAS determined in 2017 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. In 2017, this change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and corresponding action plans ("CAPs") responding to MY 2015. Instead, BH-MCOs were required to submit member-level files for MY 2016 in the summer of 2017 from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-up After Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and CAP assignments. The change coincided with the coming phase-in of Value-Based Payment (VBP) at the HC BH Contractor level in January 2018. Thus, for the first time, RCA and CAP assignments were made at the Contractor level as well as at the BH-MCO level. Contractors receiving assignments completed their RCAs and CAPs in November 2017, while BH-MCOs completed their RCAs and CAPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and CAP work on the HEDIS FUH All Ages measure and

implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY2017 performance, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs and CAPs. BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors submitted their RCAs and CAPs by April 30, 2019.

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

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

RCA for MY2018 underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): CBH Data Analysts conducted analyses of CBH paid claims for services delivered during calendar year 2018 using HEDIS and PA-HEDIS specifications. The analyses compared follow-up rates for members based on follow-up service after discharge, time to follow-up service, and age. Pay-for-Performance (P4P): CBH has included Acute Inpatient Providers (AIP) in its P4P program since 2007. The first P4P report for AIP was produced in 2010. P4P follow-up measures used for AIP have assessed providers based on admission type and whether the member had an open authorization for case management upon discharge from AIP. Telephonic Discharge Process: ➢ In order to increase 7 day and 30-day follow-up, CBH has focused on providing a follow-up call to members within 7 days of discharge from an AIP. ➢ The focus of this intervention is to gather discharge information from AIPs within 24 hours of discharge from an AIP. ➢ The intervention is being monitored via a standardized report that was created to track: ▪ number of eligible discharges from each AIP; ▪ time from AIP discharge to discharge information receipt by CBH; ▪ time from CBH receipt of information to entering the information into the CBH clinical information system; ▪ time from date of discharge to member services follow-up call attempt. • This information is tracked monthly and reviewed by Quality Management, Clinical Management, and Member Services. 7 day/30-day follow-up Report: CBH created a standardized follow-up report in the 4th quarter of 2018 that provides up-to-date provider specific data for 7 and 30-day follow-up with only a four month lag due to claims submission.	***Describe here your overall findings. Please explain the underperformance using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** [Objects removed] Our analyses indicate that, while children (members <18 years old) make up a comparatively small proportion of total acute inpatient episodes (14.85%), they do have higher follow-up rates. Analyses further showed that, for those members who did follow-up after discharge, the majority received mental health outpatient services, followed by "other" services. The "other" category is defined as community based services that are not considered follow-up services in the HEDIS specifications, and is primarily comprised of CTT, Crisis Intervention Services, ACT, and Community Integrated Recovery Centers (CBH's transformed day treatment programs). Analysis of days from discharge to follow-up service indicated that 11.9% of all episodes with a follow-up visit occur on the same day as discharge, and therefore are excluded from the numerator for both 7- and 30-day follow-up metrics. The modal number of days from discharge to follow-up was 1-5 (21.55%), and the percent of follow-up services declined over time. This means that, for members who follow-up after discharge from the hospital, they are receiving that service between 0-5 days after discharge. This pattern held for both adults and children. Telephonic Discharge Report: Results from the Telephonic Discharge Report show that Enhanced Aftercare Planning and Telephonic Analysis of the Telephonic Discharge report during the project's pilot phase showed that it allowed the Member Services

	team to reach out to members almost three days sooner than they had previously (4.9 days vs. 7.7 days). However, the gains during the initial phase of the Telephonic Discharge implementation have not been sustained. 7-/30-day Follow-up Report: This report has allowed CBH to identify providers with low follow-up rates on an ongoing basis and to use this information during discussions between providers and Clinical leadership.
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 in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
People ***(1)*** *(e.g., personnel, patients)* 1. Member does not follow discharge plan a. Members do not understand the discharge plan b. AIPs do not spend sufficient time explaining the Discharge Management Plan (DMP) to members c. Staff resources at AIP are limited and they do not have the time to ensure that the DMP is thoroughly understood by the member. d. AIPs view the main goal of treatment to be stabilization and discharge planning becomes less of a priority in the overall treatment process.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** Baseline data from our Performance Improvement Project (PIP) showed that only 62.3% of members stated they understood their DMP and only 43.7% said they followed through with their Discharge Management Plan (DMP). Additionally, if a member reported that they did not understand their DMP, 91.8% did not follow through with the DMP recommendations. Additional results of the RCA from our PIP indicated that discharge planning is not prioritized at AIPs and the purpose of AIP treatment is not explained to members. The AIPs are not given sufficient time to engage in the psycho-educational component of the discharge management plan (i.e. explaining the different components of the discharge plan). CBH addressed this through a retraining of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day action plan intervention. CBH staff conducted DMP audits that examined 4 broad areas among members that were discharged to a lower level of care: (1) was a discharge management plan present, (2) was there documentation that the member received the plan, (3) were medications documented completely at admission and discharge, and (4) was follow-up information documented completely. Results from the DMP audit found that most of our facilities have much of the information that is requested, but often struggled in one or two key areas (for instance, the information may be present in the chart, but it's not on the DMP). Therefore, providers are collecting the required information; it is just not uniformly being communicated to the member. In addition, some

	minor variation in the goals exists between providers based on provider-specific criteria. CBH will address this through a retraining of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day action plan intervention.
People ***(2)*** *(e.g., personnel, patients)* 2. Member does not understand the importance of follow-up: a. Member feels better. b. AIP treatment provided relief of symptoms that may be temporary. c. Member does not understand the chronic nature of mental illness. d. AIP does not spend sufficient time to explain DMP to member (psycho-education component of DMP).	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** In addition to the causal factors listed above, members do not understand the purpose of follow-up because the purpose of AIP treatment is not explained to members. The AIPs are also not giving sufficient time to engage in the psycho-educational component of the discharge management plan (i.e. explaining the different components of the discharge plan). CBH will address this through a retraining of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day action plan intervention.
People (3) 3. Members do not follow through with the aftercare provider identified in DMP, but rather a provider of their choice a. Members are not involved in discharge planning decisions b. AIPs are not engaging members regarding their aftercare planning c. AIP discharge planners do not have sufficient time to engage members d. Other operational/administrative concerns take priority e. AIPs place emphasis on members' stabilization during their AIP stay only	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Not Actionable*** Although members go to a different provider, they are still considered to be completing follow-up and would meet the 7-day/30-day follow-up measure. Any intervention to address this root cause would not impact the overall 7-day/30-day follow-up measures.
People (4) 4. Members have co-occurring substance use disorders a. Treatment of member's co-occurring substance use disorders may not be included in DMP. b. Members' addiction may interfere with their ability to keep follow-up appointments.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** The AIPs also do not consistently include co-occurring substance use treatment in DMPs, they are not giving sufficient time to engage in the psycho-educational component of the discharge management plan (i.e. explaining the different components of the discharge plan), and are not sufficiently involving members in discharge planning decisions. CBH will address this through a retraining of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day action plan intervention.

People (5) 5. Social Determinants of Health (SDoH) may interfere with members' ability to follow-up after discharge a. Providers are not identifying SDoH in DMPs.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Not Actionable*** Although AIPs should address social determinants of health that may prevent a member from following through with their discharge plan in the discharge planning process, it is difficult for AIPs to completely control the impacts of SDoH after the member has been discharged.
Providers ***(1)*** *(e.g. provider facilities, provider network)* 1. AIP providers not following discharge planning processes	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** CBH staff conducted DMP audits that examined 4 broad areas among members that were discharged to a lower level of care: (1) was a discharge management plan present, (2) was there documentation that the member received the plan, (3) were medications documented completely at admission and discharge, and (4) was follow-up information documented completely. Results from the DMP audit found that most of our facilities have much of the information that is requested, but often struggled in one or two key areas (for instance, the information may be present in the chart, but it's not on the DMP). Therefore, providers are collecting the required information; it is just not uniformly being communicated to the member. In addition, some minor variation in the goals exists between providers based on provider-specific criteria. CBH will address this through the 7-day 30-day action plan intervention.
Providers ***(2)*** *(e.g. provider facilities, provider network)* 2. No warm transition between AIP and Outpatient (OP) providers a. Lack of relationships between AIP and OP providers b. Difficulty connecting (scheduling conflicts, no clear contact person at OP/AIP) c. No clear process to facilitate communication d. No clear owner of this process at inpatient, outpatient, or CBH to establish regular communication and relay information from inpatient to outpatient providers e. AIPs feels they are no longer responsible for member after discharge f. OP providers do not receive discharge information from IP providers g. OP providers can't bill for services provided until after member is discharge from hospital.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** AIP and OP providers identified multiple perceived barriers to warm transitions of care from AIP to OP treatment during Inpatient/Outpatient provider forums and P4P/VBP Advisory Committee meetings. CBH will hold regular, ongoing Inpatient/Outpatient providers forums to facilitate discussion between AIP and OP providers, which will enable providers to develop relationships, identify barriers specific to their programs and strategies to overcoming those barriers. CBH will also identify providers who are successful at warm transitions to present on best

	practices. CBH will also continue to develop an enhanced rate for OP providers who are able to connect with a member within 7 days of discharge.
Policies / Procedures(1) 1. CBH Pay for Performance (P4P) Incentives are not an effective means of encouraging follow-up a. Perception of AIPs is that the cost of improving follow-up is not offset by the P4P award b. Providers receive P4P performance results 1-2 years after services have been delivered, making continuous quality improvement efforts more difficult to implement. *c.* CBH communication with AIP providers has focused on performance versus quality improvement.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Actionable*** [Objects removed] The attached P4P results from 2014-2018 for the measure IP01: 7-Day Follow-up show that provider performance has remained relatively flat over time (please note that this P4P measure includes services that may not be included in the PA HEDIS 7-Day Follow-up measure). Discussions with AIP providers in the Inpatient/Outpatient Provider Forum and VBP/P4P Advisory Committee indicate that providers may not perceive that the cost of improving follow-up, such as through the hiring of additional staff, may not be offset by P4P incentives. In addition, AIPs receive their P4P results on an annual basis, at the end of the calendar year following the end of the measurement year. Therefore, P4P results include services that have been delivered almost 2 years prior to when AIPs receive feedback on their performance. This makes it difficult for AIPs to determine whether their continuous quality improvement efforts have had an impact. CBH communication with providers during meetings with Provider Operations, Clinical Care Management, and Network Improvement and Accountability Collaborative (NIAC) have focused on performance versus exploring quality improvement using standard CQI processes.
Policies / Procedures(2) 2. CBH is not consistently connecting with members to ensure that follow-up occurs within 7-days of discharge	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Actionable*** Data from the telephonic discharge pilot implemented for our PIP indicated CBH was not enforcing the requirement for 24-hour submission of discharge information that is stated in its agreement with the providers. Furthermore, CBH was not prioritizing receiving discharge information from providers and even when received, entry of the information into the CBH electronic health record was not prioritized. Time and resources constraints at CBH resulted in CBH prioritizing the completion of initial and concurrent reviews.

Policies / Procedures (3) *(e.g., data systems, delivery systems, payment/reimbursement)* 3. Insufficient resources for thorough continuous quality improvement (CQI) process d. Insufficient staff resources to continue DMP audits with AIPs. e. CBH has not had staff resources to develop data dashboards for more timely reporting of provider performance, both internally and to providers. f. Insufficient staff resources for corrective action plan monitoring for consistently under-performing providers.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important*** ***Current and expected actionability: Actionable*** Historically, CBH has not had the staff resources to conduct ongoing CQI processes with providers, and instead focused on performance measurement and reporting. CBH staff had conducted DMP audits as part of the PIP but had found that the resources required for ongoing audits was not sufficient, and so DMP audits were discontinued. In addition, CBH Clinical, Performance Evaluation, and Provider Operations staff relied on P4P reports, which are produced annually, to measure provider performance. CBH did not have staff who could develop performance dashboards with more real-time data for both internal use and for quality improvement discussions with providers. CBH also has not historically had sufficient staff resources to monitor corrective action plans for consistently under-performing providers.
Policies / Procedures (4) *(e.g., data systems, delivery systems, payment/reimbursement)* 4. Clinical performance standards not consolidated or uniformly communicated to CBH staff or providers a. Clinical performance standards for AIPs have historically been communicated to providers through Provider Notices and Bulleting and have not been consolidated into one clinical performance standards document. b. Clinical performance standards and expectations have not been communicated in an organized way both internally to CBH staff and to providers. c. Not having consolidated clinical performance standards has led to siloed performance and quality improvement efforts across departments and with providers.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Actionable*** Historically, CBH has communicated performance standards to providers through P4P operational definitions, Provider Notices, and Bulletins. Performance standards have not been consolidated in one document that includes standards for all CBH initiatives and has not communicated those standards to CBH staff or providers in an organized manner. This has led to siloed efforts within CBH staff and with providers for quality improvement efforts.
Policies / Procedures (5) *(e.g., data systems, delivery systems, payment/reimbursement)* 5. CBH Services not being counted as follow-up	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Not Actionable*** CBH has analyzed follow-up services for members discharged from AIP and found that there were members were utilizing clinically appropriate step-down services, such as partial hospitalization and Community Integrated Recovery Centers, that were not counted as follow-up in the HEDIS or PA HEDIS specifications. As these services are not considered follow-up for the purposes of the PA HEDIS measures, CBH cannot impact its follow-up results for this causal factor.

Provisions ***(1)*** *(e.g., screening tools, medical record forms, transportation)* 1. Transportation to aftercare appointments for members a. Members have difficulty traveling to their aftercare appointments b. Members have transportation needs that are unmet c. Transportation needs were not adequately addressed prior to discharge from the AIP facility d. AIPs and CBH do not routinely include an assessment of transportation needs in a member's concurrent review or discharge planning process	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Unknown*** ***Current and expected actionability: Not Actionable*** CBH currently does not have data showing the impact of transportation difficulties on 7-day/30-day follow-up. Unable to determine attainability or impact.

Quality Improvement Plan for CY 2020

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

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

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.*
Member does not follow discharge plan. DMP audits indicated that providers are collecting the required information; it is just not uniformly being communicated to the member.	• CBH will retrain the Clinical Care Management staff, enhancing the concurrent review process • CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, ongoing • Start date: 4/1/2020, quarterly	• Clinical Care Management trainings emphasize the overall clinical review process (initial, concurrent, and discharge) to focus on assessing barriers/challenges that could prevent a member from following up with aftercare recommendations while a member is still engaged in inpatient treatment. The training modules have been incorporated into the new hire training curriculum for CBH Clinical Care Managers. CBH has also changed the concurrent review process by ensuring that the concurrent review takes place on day five or day seven of a member's hospitalization. Concurrent review questions and Discharge question have been incorporated into all Clinical

			Care Management training. Supervisors will do monthly random audits to ensure that barriers/challenges to follow-up are addressed in the discharge plans and that the concurrent review is taking place on day five or day seven of a member's hospitalization. • CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP). CBH staff will monitor provider performance quarterly to determine whether the CAP is improving 7-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle improvement process.
Member does not understand the importance of follow-up	• CBH will retrain the Clinical Care Management staff, enhancing the concurrent review process • CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, ongoing • Start date: 4/1/2020, quarterly	• Clinical Care Management trainings emphasize the overall clinical review process (initial, concurrent, and discharge) to focus on assessing barriers/challenges that could prevent a member from following up with aftercare recommendations while a member is still engaged in inpatient treatment. The training modules have been incorporated into the new hire training curriculum for CBH Clinical Care Managers. CBH has also changed the concurrent review process by ensuring that the concurrent review takes place on day five or day seven of a member's hospitalization. Concurrent review questions and Discharge question have been incorporated into all Clinical Care Management training. Supervisors will do monthly random audits to ensure that barriers/challenges to follow-up are addressed in the discharge plans, that the DMP has been communicated to the members, and that the concurrent review is taking place on day five or day seven

			of a member's hospitalization. • CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP). CBH staff will monitor provider performance quarterly to determine whether the CAP is improving 7-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle improvement process.
Members have co-occurring substance use disorders	• CBH will retrain the Clinical Care Management staff, enhancing the concurrent review process • CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, ongoing • Start date: 4/1/2020, quarterly	• Concurrent review questions and Discharge questions have been incorporated into all Clinical Care Management training. Supervisors will do monthly random audits to ensure that barriers/challenges to follow-up are addressed in the discharge plans, co-occurring substance use disorders are addressed in the DMP, and that the concurrent review is taking place on day five or day seven of a member's hospitalization. • CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP). CBH staff will monitor provider performance quarterly to determine whether the CAP is improving 7-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle improvement process.
IP providers not following discharge planning processes	• CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, quarterly	• CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP) that addresses how the provider will ensure that DMPs are being followed and that providers are communicating the DMP to CBH Clinical Care Management staff within 24 hours. CBH staff will monitor provider performance

			quarterly to determine whether the CAP is improving 7-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle improvement process.
No warm transition between AIP and Outpatient (OP) providers	• CBH will facilitate Inpatient/Outpatient forums to assist providers with development of relationships. • CBH will invite high performing AIPs to present on best practices. • CBH will give OP providers a list of the most frequently utilized AIPs by members at their program, to assist them with targeted relationship development. • CBH will continue to explore the development of a rate enhancement for OP providers for 7-day follow-up	• Start date: 6/1/2020, quarterly • Start date: 6/1/2020, quarterly • Start date: 5/1/2020, annually • Start date: 7/1/2020, one-time implementation	• CBH will participate in Inpatient/Outpatient forums to gather feedback from providers on barriers to follow-up. CBH will incorporate any CBH-focused barriers into CBH processes. CBH will include questions about the utility of these forums in the annual CBH provider survey. • CBH will determine which providers are consistently high performing and which provider dyads (AIP/OP) are most successful at achieving follow-up, and will invite them to present at the Inpatient/Outpatient provider forums. CBH will include questions about the utility of these forums in the annual CBH provider survey. • CBH will produce reports for each of the OP providers. CBH measures follow-up for OP providers through P4P, and will use P4P results to determine whether these lists are effective in assisting OP providers with targeting their outreach efforts with AIPs. • CBH will work with its claims vendor to explore the implementation of an enhanced rate for OP providers if a member follows-up with that provider within 7 days of discharge from IP. Determination of the effectiveness of this intervention will be determined by an increase in the 7-day follow-up rate.

CBH Pay for Performance (P4P) Incentives are not an effective means of encouraging follow-up	• Adult AIP providers were moved to a shared savings value-based payment (VBP) model on January 1, 2020. Savings will be obtained from a reduction in AIP cost. Providers will be eligible for a bonus in addition to the shared savings for 7- and 30-day follow-up and 30-day readmission • As part of the VBP arrangement, CBH will make member-level data and scorecards available to providers on a quarterly basis.	• Start date: 1/1/2020, ongoing • 5/1/2020, quarterly	• CBH will assess whether AIPs have reduced utilization and have achieved benchmarks for 7- and 30-day follow-up and will pay any savings and bonuses to AIP providers on a quarterly basis. • CBH staff will monitor provider performance for 7-day follow-up quarterly and will use this data to identify under-performing providers who will be required to complete a corrective action plan.
CBH is not consistently connecting with members to ensure that follow-up occurs within 7-days of discharge	• CBH will continue to ensure that Clinical Care Management and Member Services staff are prioritizing discharge planning and ensuring follow-up within 7 days.	• 4/1/2020, ongoing	• CBH will ensure that training of Clinical Care Management staff prioritizes obtaining discharge information from AIPs and entering discharge information into CBH's clinical information system. CBH will also ensure that a follow-up call by Member Services to members occurs within 7-days of discharge from an AIP. Supervisors will do monthly random audits to ensure that discharge plans are being prioritized by Clinical Care Managers and Member Services. • CBH will also monitor whether providers are delivering discharge plans to Clinical Care Managers within 24 hours. Any provider that consistently falls below baseline for this standard will be required to do a corrective action plan.
Insufficient resources for thorough CQI process.	• CBH has hired two Analysts to develop data dashboards to assist with care management decisions and performance evaluation • CBH will hire an additional Quality Improvement Specialist to assist with continuous quality improvement efforts.	• 1/1/2020, one-time • 5/1/2020,	• Analysts hired by CBH have already developed 7- and 30-day follow-up dashboards that allow users to view provider-level performance with only a 4-month claims lag.

		one-time	• The Quality Improvement Specialist will monitor corrective action plans for consistently under-performing providers and will continue the DMP audit process to identify areas for improvement.
Clinical performance standards not consolidated or uniformly communicated to CBH staff or providers	• CBH will develop Clinical Performance Standards for providers that incorporates performance standards for providers from across CBH initiatives.	• 4/1/2020, updated annually	• The Clinical Performance Standards will be used to communicate provider performance and practice standards and expectations, and will use them monitor provider performance across interventions, including for 7- and 30-day follow-up. These Clinical Performance Standards will be communicated to providers and across CBH departments and will be updated annually.

CBH: Community Behavioral Health; QIP: Quality Improvement Plan; CY: contract year; FUH: Follow-up After Hospitalization for Mental Illness; MY: measurement year; HC: health care; BH: behavioral health; MCO: managed care organization; DMP: Discharge Management Plan; CAP: corrective action plan; OP: outpatient; P4P: pay-for-performance; AIP: acute inpatient providers; VBP: value-based payment; CQI: continuous quality improvement.

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

RCA for MY2018 underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): CBH Data Analysts conducted analyses of CBH paid claims for services delivered during calendar year 2018 using Pay-for-Performance (P4P), HEDIS and PA-HEDIS specifications. The analyses compared follow-up rates for members based on follow-up service after discharge, time to follow-up service, diagnosis, age, gender, race/ethnicity, and 302 status at admission. Enhanced aftercare planning: During year one of our Performance Improvement Plan (PIP), CBH implemented enhanced aftercare planning, which requires all AIP providers to enter discharge information into a discharge template in our Clinical Information System (Dashboard), which is then forwarded automatically to a Member Services Representative who will outreach to the member within 7 days to ensure follow-up with aftercare. Enhanced aftercare was expanded in year two of the PIP to include telephonic discharge, which requires that discharge information only be given to CBH via a live telephone consult with a Clinical Care Manager. Data from the discharge templates entered into Dashboard and telephonic discharge report allows CBH to monitor progress towards the goal of the CCM's receipt of discharge information within 24 hours and Member Services outreach to the member within 7 days of AIP discharge. 7-/30-day Follow-up Report: CBH created a standardized follow-up report in the 4th quarter of 2018 that provides up-to-date provider specific data for a 7- and 30-day follow-up with only a four month lag due to claims submission.	***Describe here your overall findings. Please explain the underperformance using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** [Objects removed] Our analyses indicate that, while children (members <18 years old) make up a comparatively small proportion of total acute inpatient episodes, they do have higher follow-up rates. Analyses further showed that, for those members who did follow-up after discharge, the majority received mental health outpatient services, followed by "other" services. The "other" category is defined as community based services that are not considered follow-up services in the HEDIS specifications, and is primarily comprised of CTT, Crisis Intervention Services, ACT, and Community Integrated Recovery Centers (CBH's transformed day treatment programs). Analysis of days from discharge to follow-up service indicated that 11.9% of all episodes with a follow-up visit occur on the same day as discharge, and therefore are excluded from the numerator for both 7- and 30-day follow-up metrics. The modal number of days from discharge to follow-up was 1-5 (21.55%), and the percent of follow-up services declined over time. This means that, for members who follow-up after discharge from the hospital, they are receiving that service between 0-5 days after discharge. This pattern held for both adults and children. Further analyses showed similar trends of children following-up at higher rates than adults, with the lowest follow up rates occurring for 18-24-year-old members. There was no significant difference between race/ethnicity or between women and men. However, analyses from our Pay-for-Performance (P4P) data, which also looks at 30-day follow-up for members admitted to AIP on a 302 versus and non-302, indicate that members admitted on a non-302 follow-up at lower rates after discharge than those who didn't. During discussions with CBH, providers have indicated that a percentage of 302 admissions can be attributed to homeless status of members (members are seeking shelter at the AIPs). The analyses also show that the number of children being admitted to AIP has been decreasing and, concurrently, the proportion of children contributing to total 302 admissions has been decreasing. Telephonic Discharge Report: Results from the Telephonic Discharge Report show that Enhanced Aftercare Planning and Telephonic Discharge has allowed the Member Services team to reach out to members almost three days sooner than they had previously (4.9 days vs. 7.7 days). However, sustaining these results has been extremely labor intensive. 7-/30-day Follow-up Report: This report has allowed CBH to identify low providers with low follow-up rates on an ongoing basis and to use these rates during discussions between providers and Clinical leadership.
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 in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
People (1) *(e.g., personnel, patients)*	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very***

1. Member does not follow discharge plan a. Members do not understand the discharge plan b. AIPs do not spend sufficient time explaining the Discharge Management Plan (DMP) to members c. Staff resources at AIP are limited and they do not have the time to ensure that the DMP is thoroughly understood by the member. d. AIPs view the main goal of treatment to be stabilization and discharge planning becomes less of a priority in the overall treatment process.	***Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** Baseline data from our PIP showed that only 62.3% of members stated they understood their DMP and only 43.7% said they followed through with their Discharge Management Plan (DMP). Additionally, if a member reported that they did not understand their DMP, 91.8% did not follow through with the DMP recommendations. Additional results of the RCA from our PIP indicated that discharge planning is not prioritized at AIPs and the purpose of AIP treatment is not explained to members. The AIPs are not given sufficient time to engage in the psycho-educational component of the discharge management plan (i.e. explaining the different components of the discharge plan). CBH addressed this through a retraining of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day action plan intervention. CBH staff conducted DMP audits that examined 4 broad areas among members that were discharged to a lower level of care: (1) was a discharge management plan present, (2) was there documentation that the member received the plan, (3) were medications documented completely at admission and discharge, and (4) was follow-up information documented completely. Results from the DMP audit found that most of our facilities have much of the information that is requested, but often struggled in one or two key areas (for instance, the information may be present in the chart, but it's not on the DMP). Therefore, providers are collecting the required information; it is just not uniformly being communicated to the member. In addition, some minor variation in the goals exists between providers based on provider-specific criteria. CBH will address this through a training of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day corrective action plan intervention.
People (2) *(e.g., personnel, patients)* 2. Member does not understand the importance of follow-up: a. Member feels better. b. AIP treatment provided relief of symptoms that may be temporary. c. Member does not understand the chronic nature of mental illness. d. AIP does not spend sufficient time to explain DMP to member (psycho-education component of DMP).	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** In addition to the causal factors listed above, members do not understand the purpose of follow-up because the purpose of AIP treatment is not explained to members. The AIPs are also not giving sufficient time to engage in the psycho-educational component of the discharge management plan (i.e. explaining the different components of the discharge plan). CBH will address this through a training of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day corrective action plan intervention.
People (3) 3. Members do not follow through with the aftercare provider identified in DMP, but rather a provider of their choice a. Members are not involved in discharge planning decisions b. AIPs are not engaging members regarding their aftercare planning c. AIP discharge planners do not have sufficient time to engage members d. Other operational/administrative concerns	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Not Actionable*** Although members go to a different provider, they are still considered to be completing follow-up and would meet the 7-day/30-day follow-up measure. Any intervention to address this root cause would not impact the overall 7-day/30-day follow-up measures.

take priority e. AIPs place emphasis on members' stabilization during their AIP stay only	
People (4) 4. Members have co-occurring substance use disorders a. Treatment of member's co-occurring substance use disorders may not be included in DMP. b. Members' addiction may interfere with their ability to keep follow-up appointments.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** The AIPs also do not consistently include co-occurring substance use treatment in DMPs, they are not giving sufficient time to engage in the psycho-educational component of the discharge management plan (i.e. explaining the different components of the discharge plan), and are not sufficiently involving members in discharge planning decisions. CBH will address this through a training of the Clinical Care Management staff, enhancing the concurrent review process, and through the 7-day 30-day corrective action plan intervention.
People (5) 5. Social Determinants of Health (SDoH) may interfere with members' ability to follow-up after discharge a. Providers are not identifying SDoH in DMPs.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Not Actionable*** Although AIPs should address social determinants of health that may prevent a member from following through with their discharge plan in the discharge planning process, it is difficult for AIPs to control the impacts of SDoH after the member has been discharged.
Providers (1) *(e.g. provider facilities, provider network)* 1. IP providers not following discharge planning processes	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** CBH staff conducted DMP audits that examined 4 broad areas among members that were discharged to a lower level of care: (1) was a discharge management plan present, (2) was there documentation that the member received the plan, (3) were medications documented completely at admission and discharge, and (4) was follow-up information documented completely. Results from the DMP audit found that most of our facilities have much of the information that is requested, but often struggled in one or two key areas (for instance, the information may be present in the chart, but it's not on the DMP). Therefore, providers are collecting the required information; it is just not uniformly being communicated to the member. In addition, some minor variation in the goals exists between providers based on provider-specific criteria. CBH will address this through the 7-day 30-day corrective action plan intervention.
Providers (2) *(e.g. provider facilities, provider network)* 2. No warm transition between AIP and Outpatient (OP) providers a. Lack of relationships between AIP and OP providers b. Difficulty connecting (scheduling conflicts, no clear contact person at OP/AIP) c. No clear process to facilitate communication	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Critical*** ***Current and expected actionability: Actionable*** AIP and OP providers identified multiple perceived barriers to warm transitions of care from AIP to OP treatment during Inpatient/Outpatient provider forums and P4P/VBP Advisory Committee meetings. CBH will hold regular, ongoing

d. No clear owner of this process at inpatient, outpatient, or CBH to establish regular communication and relay information from inpatient to outpatient providers e. AIPs feels they are no longer responsible for member after discharge f. OP providers do not receive discharge information from IP providers g. OP providers can't bill for services provided until after member is discharge from hospital.	Inpatient/Outpatient providers forums to facilitate discussion between AIP and OP providers, which will enable providers to develop relationships, identify barriers specific to their programs and strategies to overcoming those barriers. CBH will also identify providers who are successful at warm transitions to present on best practices. CBH will also continue to develop an enhanced rate for OP providers who are able to connect with a member within 7 days of discharge.
Policies / Procedures(1) 1. CBH Pay for Performance (P4P) Incentives are not an effective means of encouraging follow-up a. Perception of AIPs is that the cost of improving follow-up is not offset by the P4P award b. Providers receive P4P performance results 1-2 years after services have been delivered, making continuous quality improvement efforts more difficult to implement. *c.* CBH communication with AIP providers has focused on performance versus quality improvement.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Actionable*** [Objects removed] The attached P4P results from 2014-2018 for the measure IP02: 30-Day Follow-up show that provider performance has remained relatively flat over time (please note that this P4P measure includes services that may not be included in the PA HEDIS 30-Day Follow-up measure). Discussions with AIP providers in the Inpatient/Outpatient Provider Forum and VBP/P4P Advisory Committee indicate that providers may not perceive that the cost of improving follow-up, such as through the hiring of additional staff, may not be offset by P4P incentives. In addition, AIPs receive their P4P results on an annual basis, at the end of the calendar year following the end of the measurement year. Therefore, P4P results include services that have been delivered almost 2 years prior to when AIPs receive feedback on their performance. This makes it difficult for AIPs to determine whether their continuous quality improvement efforts have had an impact. CBH communication with providers during meetings with Provider Operations, Clinical Care Management, and Network Improvement and Accountability Collaborative (NIAC), have focused on performance versus exploring quality improvement using standard CQI processes.
Policies / Procedures(2) 2. CBH is not consistently connecting with members to ensure that follow-up occurs within 7-days of discharge	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Actionable*** Data from the telephonic discharge pilot implemented for our PIP indicated CBH was not enforcing the requirement for 24-hour submission of discharge information that is stated in its agreement with the providers. Furthermore, CBH was not prioritizing receiving discharge information from providers and even when received, entry of the information into the CBH electronic health record was not prioritized. Time and resources constraints at CBH resulted in CBH prioritizing the completion of initial and concurrent reviews.
Policies / Procedures (3) *(e.g., data systems, delivery systems, payment/reimbursement)* 3. Insufficient resources for thorough continuous quality improvement (CQI) process d. Insufficient staff resources to continue DMP	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Important*** ***Current and expected actionability: Actionable***

audits with AIPs. e. CBH has not had staff resources to develop data dashboards for more timely reporting of provider performance, both internally and to providers. f. Insufficient staff resources for corrective action plan monitoring for consistently under-performing providers.	Historically, CBH has not had the staff resources to conduct ongoing CQI processes with providers, and instead focused on performance measurement and reporting. CBH staff had conducted DMP audits as part of the PIP but had found that the resources required for ongoing audits was not sufficient, and so DMP audits were discontinued. In addition, CBH Clinical, Performance Evaluation, and Provider Operations staff relied on P4P reports, which are produced annually, to measure provider performance. CBH did not have staff who could develop performance dashboards with more real-time data for both internal use and for quality improvement discussions with providers. CBH also has not historically had sufficient staff resources to monitor corrective action plans for consistently under-performing providers.
Policies / Procedures (4) *(e.g., data systems, delivery systems, payment/reimbursement)* 4. Clinical performance standards not consolidated or uniformly communicated to CBH staff or providers a. Clinical performance standards for AIPs have historically been communicated to providers through Provider Notices and Bulleting and have not been consolidated into one clinical performance standards document. b. Clinical performance standards and expectations have not been communicated in an organized way both internally to CBH staff and to providers. c. Not having consolidated clinical performance standards has led to siloed performance and quality improvement efforts across departments and with providers.	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Actionable*** Historically, CBH has communicated performance standards to providers through P4P operational definitions, Provider Notices, and Bulletins. Performance standards have not been consolidated in one document that includes standards for all CBH initiatives and has not communicated those standards to CBH staff or providers in an organized manner. This has led to siloed efforts within CBH staff and with providers for quality improvement efforts.
Policies / Procedures (5) *(e.g., data systems, delivery systems, payment/reimbursement)* 6. CBH Services not being counted as follow-up	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Somewhat Important*** ***Current and expected actionability: Not Actionable*** CBH has analyzed follow-up services for members discharged from AIP and found that there were members were utilizing clinically appropriate step-down services, such as partial hospitalization and Community Integrated Recovery Centers, that were not counted as follow-up in the HEDIS or PA HEDIS specifications. As these services are not considered follow-up for the purposes of the PA HEDIS measures, CBH cannot impact its follow-up results for this causal factor.
Provisions (1) *(e.g., screening tools, medical record forms, transportation)* 1. Transportation to aftercare appointments for members a. Members have difficulty traveling to their aftercare appointments b. Members have transportation needs that are unmet c. Transportation needs were not adequately addressed prior to discharge from the AIP facility	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): Unknown*** ***Current and expected actionability: Not Actionable*** CBH currently does not have data showing the impact of transportation difficulties on 7-day/30-day follow-up. Unable to determine attainability or impact.

d. AIPs and CBH do not routinely include an assessment of transportation needs in a member's concurrent review or discharge planning process	

Quality Improvement Plan for CY 2020

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

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

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.*
Member does not follow discharge plan. DMP audits indicated that providers are collecting the required information; it is just not uniformly being communicated to the member.	• CBH will retrain the Clinical Care Management staff, enhancing the concurrent review process • CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, ongoing • Start date: 4/1/2020, quarterly	• Clinical Care Management trainings emphasize the overall clinical review process (initial, concurrent, and discharge) to focus on assessing barriers/challenges that could prevent a member from following up with aftercare recommendations while a member is still engaged in inpatient treatment. The training modules have been incorporated into the new hire training curriculum for CBH Clinical Care Managers. CBH has also changed the concurrent review process by ensuring that the concurrent review takes place on day five or day seven of a member's hospitalization. Concurrent review questions and discharge questions have been incorporated into all Clinical Care Management training. Supervisors will do monthly random audits to ensure that barriers/challenges to follow-up are addressed in the discharge plans and that the concurrent review is taking place on day five or day seven of a member's hospitalization. • CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP). CBH staff will monitor provider performance quarterly to determine whether the CAP is improving 30-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle improvement process.

Member does not understand the importance of follow-up	• CBH will retrain the Clinical Care Management staff, enhancing the concurrent review process • CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, ongoing • Start date: 4/1/2020, quarterly	• Clinical Care Management trainings emphasize the overall clinical review process (initial, concurrent, and discharge) to focus on assessing barriers/challenges that could prevent a member from following up with aftercare recommendations while a member is still engaged in inpatient treatment. The training modules have been incorporated into the new hire training curriculum for CBH Clinical Care Managers. CBH has also changed the concurrent review process by ensuring that the concurrent review takes place on day five or day seven of a member's hospitalization. Concurrent review questions and discharge questions have been incorporated into all Clinical Care Management training. Supervisors will do monthly random audits to ensure that barriers/challenges to follow-up are addressed in the discharge plans and that the concurrent review is taking place on day five or day seven of a member's hospitalization. • CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP). CBH staff will monitor provider performance quarterly to determine whether the CAP is improving 30-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle improvement process.
Members have co-occurring substance use disorders	• CBH will retrain the Clinical Care Management staff, enhancing the concurrent review process • CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, ongoing • Start date: 4/1/2020, quarterly	• Concurrent review questions and Discharge questions have been incorporated into all Clinical Care Management training. Supervisors will do monthly random audits to ensure that barriers/challenges to follow-up are addressed in the discharge plans, co-occurring substance use disorders are addressed in the DMP, and that the concurrent review is taking place on day five or day seven of a member's hospitalization. • CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP). CBH staff will monitor provider performance quarterly to determine whether the CAP is improving 30-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle improvement process.
AIP providers not following discharge planning processes	• CBH will identify low performing providers and implement 7- and 30-day corrective action plan interventions.	• Start date: 4/1/2020, quarterly	• CBH will use claims data to identify consistently low performing providers and will require those providers to develop a corrective action plan (CAP) that addresses how the provider will ensure that DMPs are being followed and that providers are communicating the DMP to CBH Clinical Care Management staff within 24 hours. CBH staff will monitor provider performance quarterly to determine whether the CAP is improving 30-day follow-up rates for the providers. If not, CBH staff will require providers to do a rapid cycle

			improvement process.
No warm transition between AIP and Outpatient (OP) providers	• CBH will facilitate Inpatient/Outpatient forums to assist providers with development of relationships. • CBH will invite high performing AIPs to present on best practices. • CBH will give OP providers a list of the most frequently utilized AIPs by members at their program, to assist them with targeted relationship development. • CBH will continue to explore the development of a rate enhancement for OP providers for 7-day follow-up	• Start date: 6/1/2020, quarterly • Start date: 6/1/2020, quarterly • Start date: 5/1/2020, annually • Start date: 7/1/2020, one-time implementation	• CBH will participate in Inpatient/Outpatient forums to gather feedback from providers on barriers to follow-up. CBH will incorporate any CBH-focused barriers into CBH processes. CBH will include questions about the utility of these forums in the annual CBH provider survey. • CBH will determine which providers are consistently high performing and which provider dyads (AIP/OP) are most successful at achieving follow-up, and will invite them to present at the Inpatient/Outpatient provider forums. CBH will include questions about the utility of these forums in the annual CBH provider survey. • CBH will produce reports for each of the OP providers. CBH measures follow-up for OP providers through P4P, and will use P4P results to determine whether these lists are effective in assisting OP providers with targeting their outreach efforts with AIPs. • CBH will work with its claims vendor to explore the implementation of an enhanced rate for OP providers if a member follows-up with that provider within 30 days of discharge from IP. This rate will be lower than that enhanced rate for 7-day follow up. Determination of the effectiveness of this intervention will be determined by an increase in the 30-day follow-up rate.
CBH Pay for Performance (P4P) Incentives are not an effective means of encouraging follow-up	• Adult AIP providers were moved to a shared savings value-based payment (VBP) model on January 1, 2020. Savings will be obtained from a reduction in AIP cost. Providers will be eligible for a bonus in addition to the shared savings for 7- and 30-day follow-up and 30-day readmission • As part of the VBP arrangement, CBH will make member-level data and	• Start date: 1/1/2020, ongoing • 5/1/2020, quarterly	• CBH will assess whether AIPs have reduced utilization and have achieved benchmarks for 7- and 30-day follow-up and will pay any savings and bonuses to AIP providers on a quarterly basis. • CBH staff will monitor provider performance for 30-day follow-up quarterly and will use this data to identify under-performing providers who will be required to complete a corrective action plan.

	scorecards available to providers on a quarterly basis.		
CBH is not consistently connecting with members to ensure that follow-up occurs within 7-days of discharge	• CBH will continue to ensure that Clinical Care Management and Member Services staff are prioritizing discharge planning and ensuring follow-up within 7 days.	• 4/1/2020, ongoing	• CBH will ensure that training of Clinical Care Management staff prioritizes obtaining discharge information from AIPs and entering discharge information into CBH's clinical information system. CBH will also ensure that a follow-up call by Member Services to members occurs within 7-days of discharge from an AIP. Supervisors will do monthly random audits to ensure that discharge plans are being prioritized by Clinical Care Managers and Member Services. • CBH will also monitor whether providers are delivering discharge plans to Clinical Care Managers within 24 hours. Any provider that consistently falls below baseline for this standard will be required to do a corrective action plan.
Insufficient resources for thorough CQI process.	• CBH has hired two Analysts to develop data dashboards to assist with care management decisions and performance evaluation • CBH will hire an additional Quality Improvement Specialist to assist with continuous quality improvement efforts.	• 1/1/2020, one-time • 5/1/2020, one-time	• Analysts hired by CBH have already developed 7- and 30-day follow-up dashboards that allow users to view provider-level performance with only a 4-month claims lag. • The Quality Improvement Specialist will monitor corrective action plans for consistently under-performing providers and will continue the DMP audit process to identify areas for improvement.
Clinical performance standards not consolidated or uniformly communicated to CBH staff or providers	• CBH will develop Clinical Performance Standards for providers that incorporates performance standards for providers from across CBH initiatives.	• 4/1/2020, updated annually	• The Clinical Performance Standards will be used to communicate provider performance and practice standards and expectations, and will use them monitor provider performance across interventions, including for 7- and 30-day follow-up. These Clinical Performance Standards will be communicated to providers and across CBH departments and will be updated annually.

CBH: Community Behavioral Health; RCA: root cause analysis; CAP: corresponding action plan; FUH: Follow-up After Hospitalization for Mental Illness; P4P: pay-for-performance; HEDIS: Healthcare Effectiveness Data and Information Set; PIP: Performance Improvement Plan; AIP: acute inpatient providers; CCM: clinical care management; ACT: assertive community treatment; P4P: pay-for-performance; DMP: Discharge Management Plan; VBP: value-based payment; CQI: continuous quality improvement.

VI: 2019 Strengths and Opportunities for Improvement

The section provides an overview of CBH's 2019 (MY 2018) performance in the following areas: structure and operations standards, performance improvement projects, and performance measures, with identified strengths and opportunities for improvement.

Strengths

- CBH's MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate for ages 65 + was below 10% .
- CBH's MY 2018 Initiation of AOD Treatment rates for ages 18+ years and All-Ages (ages 13+ years) were statistically significantly higher (better) than the prior year.
- CBH's MY 2018 Initiation of AOD Treatment performance rate for ages 13-17 years achieved the goal of meeting or exceeding the HEDIS Quality Compass 75th percentile.
- CBH's MY 2018 Engagement of AOD Treatment performance rate for all age cuts achieved the goal of meeting or exceeding the HEDIS Quality Compass 75th percentile.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2016, RY 2017, and RY 2018 found CBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
  - CBH was partially compliant with 1 out of 7 categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category is Enrollee Rights.
  - CBH was partially compliant with 4 out of 10 categories and non-compliant with 2 out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care), 2) Provider Selection, 3) Practice Guidelines, and 4) Quality Assessment and Performance Improvement Program. The non-compliant categories are Coordination and Continuity of Care and Coverage and Authorization of Services
  - CBH was partially compliant with 8 out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Continuation of Benefits, and 8) Effectuation of Reversed Resolutions.
- CBH's overall PIP Project Performance Score was a Partial Met. They were a Partial Met on: Improvement Strategies (Interventions), Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement, and Sustainability of Documented Improvement.
  - Over the course of the PIP, CBH did not evidence significant improvement in the BHR and SAA indicators.
- CBH's MY 2018 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for all age cuts examined (6-17, 18-64, and 6+ years) were statistically significantly lower (worse) compared to the MY 2018 HC BH (Statewide) rates.
- CBH's MY 2018 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for all age cuts examined (6-17, 18-64, and 6+ years) were statistically significantly lower (worse) compared to the previous year.
- CBH's MY 2018 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6+ years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- CBH's MY 2018 PA-Specific 7-Day (QI A) and 30-day (QI B) Follow-up After Hospitalization for Mental Illness rates for the overall population were statistically significantly lower (worse) compared to the MY 2018 HC BH (Statewide) rates.
- CBH's MY 2018 PA-Specific 7-Day (QI A) and 30-day (QI B) Follow-up After Hospitalization for Mental Illness rates for the overall population were statistically significantly lower (worse) compared to the previous year.
- CBH's MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge overall rate did not meet the OMHSAS designated performance goal of 10.0%.
- CBH's MY 2018 Initiation of AOD Treatment performance rates for ages 18+ years and All-Ages l (13+ years) did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.

- CBH's MY 2018 Initiation of AOD Treatment performance rates for ages 18+ years and All-Ages (13+ years) were statistically significantly lower (worse) compared to the MY 2018 HC BH (Statewide) rates.
- CBH's MY 2018 Engagement rates for ages 18+ years and All-Ages (13+ years) were statistically significantly lower (worse) compared to the MY 2018 HC BH (Statewide) rates.
- CBH's MY 2018 Engagement rates for ages 18+ years and All-Ages (13+) were statistically significantly lower (worse) compared to the previous year.

Performance Measure Matrices

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

Table 6.1 is a three-by-three matrix depicting the horizontal same-year comparison between the BH-MCO's performance and the applicable HC BH (Statewide) rate and the vertical comparison of the BH-MCO's MY 2018 performance to its prior year performance. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═).However, the qualitative placement of the performance in the matrix depends on the measure. For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) measure, lower rates reflect better performance.

Table 6.1: BH-MCO Performance Matrix for MY 2018 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge (All Ages)

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

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

Letter Key: A: Performance is notable. BH-MCOs may have internal goals to improve. B: BH-MCOs may identify continued opportunities for improvement. C-F: Recommend BH-MCOs identify continued opportunities for improvement.

FUH QI A: PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (All Ages).

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

REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Table 6.2 quantifies the performance information presented in **Table 6.1**. It compares the BH-MCO's MY 2018 7- and 30-Day Follow-up After Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2014 through 2018. The last column compares the BH-MCO's

MY 2017 rates to the corresponding MY 2017 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly: above (▲), below (▼), or no difference (═).

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

Quality Performance Measure	MY 2014 Rate	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2018 Rate	MY 2018 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	56.9%▲	51.1%▼	**50.1%=**	**49.5%=**	**49.5%▼**	**53.1%▼**
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	71.7% ▲	67.4%▼	**64.7%▼**	**63.4%=**	**63.4%▼**	**69.6%▼**
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	13.1% ▲	13.7% =	**13.5%=**	**12.9%=**	**13.3%=**	**13.7%=**

[1] For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.

Table 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2018 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2018 HEDIS Overall (ages 6+ years) FUH 7-Day (QI1) and 30-Day Follow-up (QI2) After Hospitalization metrics. A root cause analysis (RCA) and quality improvement plan (QIP) is required for rates that fall below the 75th percentile.

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

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

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

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

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

Quality Performance Measure	MY 2018		HEDIS MY 2018 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	26.1%	Not met	Below 25th percentile
QI 2 – HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	40.5%	Not met	Below 25th percentile

[1] Rates shown are for ages 6 years and older.

VII: Summary of Activities

Structure and Operations Standards

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

Performance Improvement Projects

- CBH submitted a Year 4 PIP Update in 2018. CBH's overall PIP performance was a Partial Met.

Performance Measures

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

Quality Studies

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

2018 Opportunities for Improvement MCO Response

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

2019 Strengths and Opportunities for Improvement

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

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Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

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

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

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Substandard 60.1	Table of organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member Complaints and Grievances.
	Substandard 60.2	Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances.
	Substandard 60.3	The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H.
	Substandard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH-MCO must submit to the DHS data specified by the DHS that enable the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction, including Consumer Satisfaction Team reports to DHS.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established time frames: Annual Evaluation, QM Program Description, QM Work Plan, and Quarterly PEPS Reports.
	Substandard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Substandard 108.2	C/FST budget is sufficient to: hire staff proportionate to HealthChoices covered lives; have adequate office space; purchase equipment; travel and attend on-going training.
	Substandard 108.5	The C/FST has access to providers and HealthChoices members to conduct surveys, and employs a variety of survey mechanisms to determine member satisfaction; e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Substandard 108.6	The problem resolution process specifies the role of the County, BH-MCO, C/FST and providers, and results in timely follow-up of issues identified in quarterly surveys.
	Substandard 108.7	The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider and level of care, and narrative information about trends and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable.
	Substandard 108.8	The annual mailed/telephonic survey results are representative of HealthChoices membership, and identify systemic trends. Actions have been taken to address areas found deficient, as applicable.
	Substandard 108.10	The C/FST Program is an effective, independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement.
§438.206 Availability of Service	Substandard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages). • Excel or Access database with the following information: Name of Agency (include satellite

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

BBA Category	PEPS Reference	PEPS Language
		sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.3	Provider Exception report submitted and approved when choice of two providers is not given.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.
	Substandard 1.7	Confirm FQHC providers.
	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Substandard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Substandard	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow-

BBA Category	PEPS Reference	PEPS Language
	93.4	up After Hospitalization rates, and Consumer Satisfaction.
§438.208 Coordination and Continuity of Care	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.210 Coverage and authorization of services	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services, if applicable; and contains date denial decision will take effect).
§438.210 Provider Selection	Substandard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Substandard 10.2	100% of decisions made within 180 days of receipt of application.
	Substandard 10.3	Recredentialing incorporates results of provider profiling.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
§438.230 Subcontractual relationships and delegation	Substandard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
	Substandard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Substandard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as other medical and human services programs.
	Substandard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Substandard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds, and performance goals.
	Substandard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Substandard 99.7	Providers are evaluated based on established goals and corrective action taken, as necessary.
	Substandard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is

BBA Category	PEPS Reference	PEPS Language
	28.2	supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
§438.240 Quality assessment and performance improvement program	Substandard 91.1	The QM Program Description clearly outlines the BH-MCO QM structure.
	Substandard 91.2	The QM Program Description clearly outlines the BH-MCO QM content.
	Substandard 91.3	The QM Program Description includes the following basic elements: Performance improvement projects Collection and submission of performance measurement data Mechanisms to detect underutilization and overutilization of services Emphasis on, but not limited to, high volume/high-risk services and treatment, such as Behavioral Health Rehabilitation Services Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs.
	Substandard 91.4	The QM Work Plan includes: Objective Aspect of care/service Scope of activity Frequency Data source Sample size Responsible person Specific, measurable, attainable, realistic and timely performance goals, as applicable.
	Substandard 91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	Substandard 91.6	The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.
	Substandard 91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	Substandard 91.8	The QM Work Plan includes a provider profiling process.
	Substandard 91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: Telephone access and responsiveness rates Overall utilization patterns and trends including BHRS and other high volume/high risk services.
	Substandard 91.10	The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.
	Substandard 91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Substandard 91.12	The QM Work Plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Evaluation
	Substandard 91.13	The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year
	Substandard 91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.
	Substandard	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality

BBA Category	PEPS Reference	PEPS Language
	91.15	management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	Substandard 93.1	The BH-MCO reports monitoring results for Access to Services (e.g., routine, urgent, and emergent), Provider network adequacy, and Penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance, and appeal processes; rates of denial; and rates of grievances upheld overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow-up After Hospitalization rates, and Consumer Satisfaction.
	Substandard 98.1	The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate
	Substandard 98.2	The BH-MCO reports monitoring results for Overall Utilization Patterns and Trends, including BHRS service utilization and other high-volume/high-risk services, Patterns of over- or under-utilization identified. BH-MCO takes action to correct utilization problems, including patterns of over- and under-utilization.
	Substandard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Substandard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH-MCO must submit to the DHS data specified by the DHS that enable the measurement of the BH-MCO's performance. QM Program description must outline timeline for submission of QM Program description, Work Plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established time frames: Annual Evaluation QM Program Description, QM Work Plan, and Quarterly PEPS Reports.
§438.242 Health information systems	Substandard 120.1	The County/BH-MCO uses the required reference files as evidence through correct, complete, and accurate encounter data.
§438.400 Statutory basis and definitions	Substandard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how complaint rights procedures are made known to members, BH-MCO staff, and the provider network. ● 1st level ● 2nd level ● External ● Expedited ● Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent

BBA Category	PEPS Reference	PEPS Language
		corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; and contains date denial decision will take effect).
§438.402 General requirements	Substandard 60.1	Table of organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process, and respond to member complaints and grievances.
	Substandard 60.2	Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances.
	Substandard 60.3	The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H.
	Substandard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. ● 1st level ● 2nd level ● External ● Expedited ● Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services, if applicable; and contains date denial decision will take effect).
§438.404 Notice of action	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Substandard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.

BBA Category	PEPS Reference	PEPS Language
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access to interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services, if applicable; and contains date denial decision will take effect).
§438.406 Handling of grievances and appeals	Substandard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how complaint rights procedures are made known to members, BH-MCO staff, and the provider network. ● 1st level ● 2nd level ● External ● Expedited ● Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; and contains date denial decision will take effect).
§438.408 Resolution and notification: Grievances and appeals	Substandard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how complaint rights procedures are made known to members, BH-MCO staff, and the provider network. ● 1st level ● 2nd level ● External ● Expedited ● Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

BBA Category	PEPS Reference	PEPS Language
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; and contains date denial decision will take effect).
§438.410 Expedited resolution of appeals	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; and contains date denial decision will take effect).
§438.414 Information about the grievance system to providers and subcontractors	Substandard 68.1	Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how complaint rights procedures are made known to members, BH-MCO staff and the provider network. ● 1st level ● 2nd level ● External ● Expedited ● Fair Hearing

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, RY 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to

BBA Category	PEPS Reference	PEPS Language
		where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required time frames and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; and contains date denial decision will take effect).
§438.424 Effectuation of reversed appeal resolutions	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff, and the provider network: ● Internal ● External ● Expedited ● Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.3	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 72.2	The content of the notices adheres to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW fair hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; and contains date denial decision will take effect).

Appendix B. OMHSAS-Specific PEPS Substandards

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

Table B.1: OMHSAS-Specific PEPS Substandards

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

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

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

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, a "(RY 2016, RY 2017)" 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 2018, 16 OMHSAS-specific substandards were evaluated for CBH and Philadelphia. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in RY 2018, along with the relevant categories.

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

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2018	RY 2017	RY 2016
Care Management					
Care Management (CM) Staffing (Standard 27)	1	0	0	0	1
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	0	0	1
Complaints and Grievances					
Complaints (Standards 68 and 68.1)	4	0	0	0	4
Grievances and State Fair Hearings (Standards 71 and 71.1)	4	0	0	0	4
Denials					
Denials (Standard 72)	1	0	1	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	0	0	1
BH-MCO Executive Management (Standard 86)	1	0	0	0	1
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0
Total	16	0	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 substandards that came under active review during the cycle specific to the review year. OMHSAS: Office of Mental Health & Substance Abuse Services; CCBH: Community Care Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: sub-standards not reviewed; RY: review year; CM: Care Management; BH: Behavioral Health; MCO: managed care organization.

NR: Substandards not reviewed.

N/A: Category not applicable.

Format

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

Findings

Care Management

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. CBH was evaluated on 2 of the 2 applicable substandards. Of the 2 substandards, CBH was non-compliant with both substandards. The status for these substandards is presented in **Table C.2**.

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

Category	PEPS Item	RY	Status
Care Management			
Care Management (CM) Staffing	Substandard 27.7	2016	Not met
Longitudinal Care Management (and Care Management Record Review)	Subtandard 28.3	2016	Not met

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

CBH was non-compliant with Standard 27, Substandard 7 of (RY 2016).

> **PEPS Standard 27:** Care Management (CM) Staffing. BH-MCO Staffing Standard for care manager and physician peer reviews; FTE count of care managers and physician peer reviews; list of care manager, clinical supervisor, and medical doctor/physician assistant (MD/PA) positions; copies of care manager supervisor and care manager job descriptions; CM Staffing Schedules; CM staff-to-member ratios; UM/CM organization chart; copy of P&Ps for clinical supervision, PA case consultation, peer review of referral, and role of MD in the supervision of care managers; table of organization of the BH-MCO.
>
> **Substandard 7:** Other: Significant onsite review findings related to Standard 27.

CBH was non-compliant with Standard 28, Substandard 3 of (RY 2016).

> **PEPS Standard 28:** Longitudinal Care Management (and Care Management Record Review). Results of the Care Management Record (CMR) review, denial review, and clinical interviews (summary). Sample of CMR Records.
>
> **Substandard 3:** Other: Significant onsite review findings related to Standard 28.

Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances include MCO-specific and County-specific review standards. CBH was evaluated on 8 of the 8 applicable substandards. Of the 8 substandards evaluated, CBH partially met 3 substandards, and did not meet5 substandards, as indicated in **Table A.3**.

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

Category	PEPS Item	RY	Status
Complaints and Grievances			
Complaints	Substandard 68.1.1	2016	Partially met
	Substandard 68.6	2016	Not met
	Substandard 68.7	2016	Not met
	Substandard 68.8	2016	Not met
Grievances and State Fair Hearings	Substandard 71.1.1	2016	Partially met
	Substandard 71.5	2016	Not met
	Substandard 71.6	2016	Not met
	Substandard 71.7	2016	Partially met

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

CBH was partially compliant with Standard 68.1, Substandard 1 and was non-compliant with Standard 68, Substandards 5, 6, and 7 (RY 2016).

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

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

PEPS Standard 68: Complaint (and BBA fair hearing) rights and procedures are made known to IEAP, members, BH-MCO staff, and the provider network through manuals, training, handbooks, etc.

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

Substandard 6 (RY 2016, RY 2017): The second-level complaint case file includes documentation that the member was contacted about the 2nd-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 7 (RY 2016, RY 2017): Training rosters identify that all 2nd-level panel members have been trained. Include a copy of the training curriculum.

CBH was partially compliant with Standard 71.1, Substandard 1, and with Standard 71, Substandard 5, and non-compliant with Standard 71, Substandards 5 (RY 2016, RY 2017) and 6 (RY 2016, RY 2017)**.**

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

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

PEPS Standard 71: Grievances and State fair hearings. Grievance and fair hearing rights and procedures are made known to EAP, members, BH-MCO Staff, and the provider network through manuals, training, handbooks, etc.

Substandard 5 (RY 2016, RY 2017)**:** The second level grievance case file includes documentation that the member was contacted about the second level grievance meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.

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

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

Denials

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. CBH was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

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

Category	PEPS Item	RY	Status
Denials			
Denials	Substandard 72.3	2018	Met

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. CBH was non-compliant with 2 substandards. The status for these substandards is presented in **Table A.5**.

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

Category	PEPS Item	RY	Status
Executive Management			
County Executive Management	Substandard 78.5	2016	Not met
BH-MCO Executive Management	Substandard 86.3	2016	Not met

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

CBH was non-compliant with Standard 78, Substandard 5 (RY 2016).

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

Substandard 5: Other: Significant onsite review findings related to Standard 78.

CBH was non-compliant with Substandards 3 of Standard 86 (RY 2016).

PEPS Standard 86: BH-MCO Executive Management. Required duties and functions are in place. The BH-MCO's table of organization depicts organization relationships of the following functions/ positions: Chief Executive Officer; The appointed Medical Director is a board-certified psychiatrist licensed in Pennsylvania with at least five years of experience in mental health and substance abuse; Chief Financial Officer; Director of Quality Management; Director of Utilization Management; Management Information Systems; Director of Prior/Service Authorization; Director of Member Services; Director of Provider Services.

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

Enrollee Satisfaction

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

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

Category	PEPS Item	RY	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Substandard 108.3	2017	Met
	Substandard 108.4	2017	Met
	Substandard 108.9	2017	Met

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