



**Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Health and Substance
Abuse Services**

**2013 External Quality Review Report
Community Care Behavioral Health
FINAL REPORT**

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GLOSSARY OF TERMS

Average (i.e., arithmetic mean or mean)	The sum of all items divided by the number of items in the list. All items have an equal contribution to the calculation; therefore, this is un-weighted.
Confidence Interval	Confidence interval (CI) is a range of values that can be used to illustrate the variability associated with a given calculation. . For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would be within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.
HealthChoices Aggregate Rate	The sum of all behavioral health (BH) managed care organization (MCO) numerators divided by the sum of all BH MCO denominators.
HealthChoices BH MCO Average	The sum of the individual BH MCO rates divided by the total number of BH MCOs (five BH MCOs). Each BH MCO has an equal contribution to the HealthChoices BH MCO Average value.
HealthChoices County Average	The sum of the individual County rates divided by the total number of Counties (67 Counties). Each County has an equal contribution to the HealthChoices County Average value.
Rate	A proportion indicated as a percentage of members who received services out of the total population of identified eligible members.
Percentage Point Difference	The arithmetic difference between two rates.
Weighted Average	Similar to an arithmetic mean (the most common type of average), where instead of each of the data points contributing equally to the final average, some data points contribute more than others.
Statistical Significance	A result that is unlikely to have occurred by chance. The use of the word significance in statistics is different from the standard one, which suggests that something is important or meaningful.
Z-ratio	How far and in what direction the calculated rate diverged from the most probable result (i.e., the distribution's mean). Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.



INTRODUCTION

Purpose and Background

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.

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.

The HealthChoices Behavioral Health 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 Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2013 EQRs for the HealthChoices Behavioral Health (BH) MCOs and to prepare the technical reports. This technical report includes six core sections:

- I: Structure and Operations Standards
- II: Performance Improvement Projects
- III: Performance Measures
- IV: 2012 Opportunities for Improvement - MCO Response
- V: 2013 Strengths and Opportunities for Improvement
- VI: Summary of Activities

For the HealthChoicesBH MCOs,, the information for the compliance with the Structure and Operations Standards section of the report is derived from monitoring conducted by OMHSAS of the BH MCOs against the Commonwealth's Program Evaluation Performance Summary (PEPS) review tools and/or Readiness Assessment Instrument (RAI), as applicable.

Information for Sections II and III of this report is derived from IPRO's validation of each BH MCO's performance improvement projects (PIPs) and performance measure submissions. Performance measure validation as conducted by IPRO includes two performance measures – Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Section IV, 2012 Opportunities for Improvement – MCO Response, includes the BH MCO's responses to opportunities for improvement noted in the 2012 EQR Technical Report, and presents the degree to which the BH MCO addressed each opportunity for improvement.

Section V has a summary of the BH MCO's strengths and opportunities for improvement for this review period (2012) as determined by IPRO, and a "report card" of the BH MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HealthChoices Behavioral Health Managed Care Organization.

Section VI provides a summary of EQR activities for the BH MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA Regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.



I: STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of the BH MCO Community Care Behavioral Health's (CCBH's) compliance with the structure and operations standards. In Review Year (RY) 2012, 66 PA 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 contracts with the Commonwealth with regard to the administration of Medicaid managed care behavioral health and substance abuse services. Forty-three of the 67 Counties subcontract directly with BH MCOs to administer behavioral health services. These 43 Counties provide monitoring and oversight of the BH MCOs. The remaining 24 Counties contract directly with DPW since the Counties elected not to bid for the HealthChoices contract. Each County subsequently chose a BH MCO subcontractor, which operates under the authority of that County, to administer behavioral health and substance abuse services provided via the HealthChoices BH Program.

Adams, Allegheny, Berks, Chester and York Counties hold contracts with CCBH, and Lackawanna, Luzerne, Susquehanna, Wyoming hold a contract with Northeast Behavioral Health Care Consortium (NBHCC), that in turn holds a contract with CCBH. The North/Central County Option (NC/CO) Counties – Carbon, Monroe, and Pike also hold a contract with CCBH. For the North/Central State Option (NC/SO) Counties – Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne – OMHSAS contracted directly with CCBH to administer services in these Counties. While Medicaid managed care members may choose a Physical Health (PH) MCO for physical health care services, each HealthChoices enrollee is assigned a BH MCO based on his or her County of residence. Erie County held a contract with another MCO through June 30, 2011 and contracted with CCBH beginning July 1, 2011. IPRO's EQR is based on OMHSAS reviews of CCBH and the 35 Counties associated with the BH MCO.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CCBH by OMHSAS monitoring staff within the past three Review Years (RYs 2012, 2011, 2010). These evaluations are performed at the BH MCO and County levels, and the findings are reported in OMHSAS' PEPS review tools for Review Year (RY) 2012. 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 timeframe under consideration, the RAI was provided to IPRO. For those Counties and BH MCOs that completed their Readiness Reviews outside of the current three-year timeframe, 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 2013 and entered into the PEPS tools as of October 2013 for RY 2012. Information captured within the PEPS tools informs this report. The PEPS tools are a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each County/BH MCO.



Within each standard, the tool specifies the sub-standards 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 to collect additional reviewer comments. Based on the tools, a County/BH MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS' more rigorous monitoring criteria.

At the implementation of the PEPS tools in 2004, IPRO evaluated the standards in the tools 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' 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 & 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. As was done for the prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The RY 2012 crosswalk of PEPS Substandards to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Substandards can be found in Appendix A and B, respectively. The review findings for selected OMHSAS-specific Substandards are reported in Appendix C.

Because OMHSAS review of the Counties and their subcontracted BH MCOs expands 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 PEPS Substandards from RY 2012, RY 2011, and RY 2010 provided the information necessary for the 2013 assessment. Those standards not reviewed through the PEPS system in RY 2012 were evaluated on their performance based on RY 2011 and/or RY 2010 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed. Since Erie County contracted with two BH MCOs in 2011 and because all applicable standards were reviewed for both BH MCOs within the three-year time frame, Erie County's review findings for RY 2012, RY 2011 and RY 2010 were not included in the assessment of compliance for either BH MCO.

For CCBH, this year a total of 159 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations. In addition, 11 OMHSAS-specific Items were identified as being related to, but are supplemental to, the BBA regulation requirements. It should be noted that some PEPS Substandards were relevant to more than one BBA regulation or provision, and that one or more provisions apply to each of the categories listed within the subpart headings. Because of this, the same PEPS Item may contribute more than once to the total number of Items required and/or reviewed. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of CCBH against the Structure and Operations Standards for this report. In Appendix C, Table C.1 provides a count of supplemental OMHSAS-specific Items that are not required as part of BBA regulations, but are reviewed within the three-year cycle to evaluate the BH MCO and associated Counties against other state-specific Structure and Operations Standards.



Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for CCBH

Table 1.1a Substandards Pertinent to BBA Regulations Reviewed for Adams, Allegheny, Chester, and York Counties

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	5	7	0	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
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					
Availability of Services	22	2	4	16	0
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

* Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" Items, including those that are Not Applicable, do not substantially affect the findings for any category if other Items within the category are reviewed



Table 1.1b Substandards Pertinent to BBA Regulations Reviewed for NBHCC (Lackawanna, Luzerne, Susquehanna, and Wyoming), NC/CO (Carbon, Monroe, and Pike) and Berks Counties

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	5	7	0	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
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					
Availability of Services	22	2	4	15	1
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

* Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" Items, including those that are Not Applicable, do not substantially affect the findings for any category if other Items within the category are reviewed



Table 1.1c Substandards Pertinent to BBA Regulations Reviewed for NC/SO Counties (Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne)

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	RAI Reviewed in RY 2010	Not Reviewed*
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	5	0	7	0
Provider-Enrollee Communications	0	0	0	0	0
Marketing Activities	0	0	0	0	0
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	22	2	4	16	0
Coordination and Continuity of Care	2	2	0	0	0
Coverage and Authorization of Services	4	3	0	0	1
Provider Selection	3	0	0	3	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	0	8	0	0
Practice Guidelines	6	2	4	0	0
Quality Assessment and Performance Improvement Program	23	16	7	0	0
Health Information Systems	1	0	1	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	11	10	0	0	1
General Requirements	14	13	0	0	1
Notice of Action	11	1	0	9	1
Handling of Grievances and Appeals	11	10	0	0	1
Resolution and Notification: Grievances and Appeals	11	10	0	0	1
Expedited Appeals Process	6	5	0	0	1
Information to Providers and Subcontractors	2	2	0	0	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	5	0	0	1
Effectuation of Reversed Resolutions	6	5	0	0	1

* Items "Not Reviewed" were not scheduled or not applicable for evaluation. "Not Reviewed" Items, including those that are Not Applicable, do not substantially affect the findings for any category if other Items within the category are reviewed

For RY 2012, nine 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' 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, DPW has been granted an allowance to offer only one BH MCO per County.



In evaluations prior to the 2008 report, the categories Solvency Standards and Recordkeeping and Recording Requirements were deemed compliant across all Counties and BH MCOs based only on the HealthChoices Behavioral Health Program's PS&R and Readiness Review assessments, respectively. Beginning with the 2008 report, OMHSAS and IPRO revised the documentation requirements for these categories to reflect the ongoing monitoring of these categories by OMHSAS. Hence, Solvency Requirement tracking reports, Encounter Monthly Aggregate Complaint/Grievance records (EMG) and Encounter Monthly Complaint/Grievance Synopsis records (MCG) were reviewed to determine compliance with the Solvency and Recordkeeping and Recording Requirement standards, respectively.

Determination of Compliance

To evaluate County/BH MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision, and evaluated the Counties' 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 tools submitted by the Commonwealth. If a substandard was not evaluated for a particular County/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 County/BH MCO was evaluated as compliant; if some were met and some were partially met or not met, the County/BH MCO was evaluated as partially compliant. If all Items were not met, the County/BH MCO was evaluated as non-compliant. If no crosswalked Items were evaluated for a given provision, and no other source of information was available to determine compliance, a value of Not Applicable ('N/A') was assigned for that provision. A value of Null was assigned to a provision when none of the existing PEPS Substandards directly covered the Items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. For example, all provisions 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 the *MCO Monitoring Protocol*. Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol i.e., 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 County/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

For CCBH and the 35 Counties associated with the BH MCO included in the structure and operations standards for RY 2012, 159 PEPS Items were identified as required to fulfill BBA regulations. Adams, Allegheny, Chester, York, and NC/SO Counties were evaluated on 150 PEPS Items, with nine Items not scheduled or not applicable for evaluation for RY 2011. Berks, NBHCC, and the NC/CO Counties were evaluated on 149 Items during the review cycle, with 10 Items were not scheduled or not applicable for evaluation for RY 2012.



Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each County/BH MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the County/BH MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees [42 C.F.R. § 438.100 (a), (b)].

Table 1.2 Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections				
Subpart C: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	Allegheny, Berks, NBHCC, NC/CO, NC/SO	Chester, Adams, York	12 substandards were crosswalked to this category. Allegheny, Berks, NBHCC, NC/CO and NC/SO Counties were evaluated on 12 substandards and compliant on 12 substandards. Adams, Chester and York Counties were evaluated on 12 substandards, compliant on 11 substandards and partially compliant on 1 substandard.
Provider-Enrollee Communications 438.102	Compliant	All CCBH Counties		Compliant as per PS&R sections E.4 (p.49) and A.3.a (p.20).
Marketing Activities 438.104	N/A	N/A	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	All CCBH Counties		Compliant as per PS&R sections A.9 (p.64) and C.2 (p.30).
Cost Sharing 438.108	Compliant	All CCBH Counties		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	All CCBH Counties		Compliant as per PS&R section 3 (p.34).
Solvency Standards 438.116	Compliant	All CCBH Counties		Compliant as per PS&R sections A.3 (p.59) and A.9 (p.64), and 2012-2013 Solvency Requirements tracking report.

There are seven categories in the Enrollee Rights and Protections Standards. CCBH was compliant on five categories and partially compliant on one category. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the five compliant categories, four were compliant as per the HealthChoices PS&R and one category was compliant as per CMS Regulation 42 CFR 447.50-447.60. The category Solvency Standards was compliant based on the 2012-2013 Solvency Requirement tracking report.

Allegheny, Berks, NBHCC, NC/CO and NC/SO Counties were compliant on six categories of the Enrollee Rights and Protections Standards. The remaining three Counties – Adams, Chester and York Counties – were compliant on five categories.



Of the 12 PEPS substandards that were crosswalked to Enrollee Rights and Protections Regulations, all 12 were evaluated for the CCBH Counties. Allegheny, Berks, NBHCC, NC/CO and NC/SO Counties were compliant on all 12 substandards. Adams, Chester and York Counties were compliant on 11 substandards, and partially compliant on one substandard. 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

Adams, Chester and York Counties were partially compliant with Enrollee Rights due to partial compliance with substandards within PEPS Standard 108.

PEPS Standard 108: The County Contractor/BH/MCO: a. Incorporates consumer satisfaction information in provider profiling and quality improvement process; b. Collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of Appendix L; c. Provides the Department with Quarterly and Annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems. d. Provides an effective problem identification and resolution process.

Adams, Chester and York Counties were partially compliant on one substandard of Standard 108: Substandard 10 (RY 2011).

Substandard 10: The C/FST Program is an effective independent organization that is able to identify and influence quality improvement on behalf of individual member and system improvement.

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 C.F.R. § 438.206 (a)].

The PEPS documents for each County include an assessment of the County/BH MCO’s compliance with regulations found in Subpart D. Table 1.3 presents the findings by categories consistent with the regulations.

Table 1.3 Compliance with Quality Assessment and Performance Improvement Regulations

Quality Assessment and Performance Improvement Regulations					
Subpart D: Categories	MCO Compliance Status	By County			Comments
		Fully Compliant	Partially Compliant	Non-Compliant	
Elements of State Quality Strategies 438.204	Compliant	All CCBH Counties			Compliant as per PS&R section G.3 (p.53).



Quality Assessment and Performance Improvement Regulations					
Subpart D: Categories	MCO Compliance Status	By County			Comments
		Fully Compliant	Partially Compliant	Non-Compliant	
Availability of Services (Access to Care) 438.206	Partial		Adams, Allegheny, Berks, Chester, NBHCC, NC /CO, NC/SO York		<p>22 substandards were crosswalked to this category</p> <p>Adams, Allegheny, Chester and York Counties were evaluated on 22 substandards, compliant on 20 substandards, and non-compliant on 2 substandard.</p> <p>The Berks, NC/CO, and NBHCC Counties were evaluated on 21 substandards, compliant on 19 substandards, and non-compliant on 2 substandard.</p> <p>The NC/SO Counties were evaluated on 22 substandards, compliant on 19 substandards, partially compliant on 1 substandard and non-compliant on 2 substandards.</p>
Coordination and Continuity of Care 438.208	Non-Compliant			All CCBH Counties	<p>2 substandards were crosswalked to this category</p> <p>Each County was evaluated on 2 substandards and non-compliant on 2 substandards.</p>
Coverage and Authorization of Services 438.210	Partial		All CCBH Counties		<p>4 substandards were crosswalked to this category</p> <p>Each County was evaluated on 3 substandards, partially compliant on 1 substandard and non-compliant on 2 substandards.</p>
Provider Selection 438.214	Compliant	All CCBH Counties			<p>3 substandards were crosswalked to this category.</p> <p>Each County was evaluated on 3 substandards and compliant on 3 substandards.</p>
Confidentiality 438.224	Compliant	All CCBH Counties			Compliant as per PS&R sections D.2 (p.46), G.4 (p.55) and C.6.c (p.44).
Subcontractual Relationships and Delegation 438.230	Compliant	All CCBH Counties			<p>8 substandards were crosswalked to this category.</p> <p>Each County was evaluated on 8 substandards and compliant on 8 substandards.</p>



Quality Assessment and Performance Improvement Regulations					
Subpart D: Categories	MCO Compliance Status	By County			Comments
		Fully Compliant	Partially Compliant	Non-Compliant	
Practice Guidelines 438.236	Partial		All CCBH Counties		6 substandards were crosswalked to this category. Each County was evaluated on 6 substandards, compliant on 4 substandards and non-compliant on 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Compliant	All CCBH Counties			23 substandards were crosswalked to this category. Each County was evaluated on 23 substandards and compliant on 23 substandards.
Health Information Systems 438.242	Compliant	All CCBH Counties			1 substandard was crosswalked to this category. Each County was evaluated on 1 substandard and compliant on this substandard.

There are 10 categories in the Quality Assessment and Performance Improvement Regulations Standards. CCBH was compliant on six of the 10 categories and partially compliant on four categories – Availability of Services. Two of the six categories that CCBH was compliant on – Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS substandards, but were evaluated and determined to be compliant as per the HealthChoices Program Standards and Requirements (PS&R).

For this review, 69 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations for all 35 Counties associated with CCBH. Adams, Allegheny, Chester, and York Counties were evaluated on 68 substandards, compliant on 59 substandards, partially compliant on 1 substandard and non-compliant on 8 substandards. One substandard was not scheduled or not applicable for evaluation for RY 2012 for these Counties. The Berks, NBHCC, NC/CO Counties were evaluated on 67 substandards, compliant on 58 substandards, partially compliant on 1 substandard and non-compliant on 8 substandards. Two substandards were not scheduled or not applicable for evaluation for RY 2012 for these Counties. The NC/SO Counties were evaluated on 68 substandards, compliant on 58 substandards, partially compliant on 2 substandards and non-compliant on 8 substandards. One substandard was not scheduled or not applicable for evaluation for RY 2012 for these Counties. 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)

All of the CCBH Counties were partially compliant with Availability of Services due to non-compliance with two substandards of PEPS Standard 28.

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

All of the CCBH Counties were non-compliant on two substandards of PEPS Standard 28: Substandards 1 and 2 (RY 2012)



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.

The NC/SO Counties were partially compliant with Availability of Services due to partial compliance with one substandard of PEPS Standard 1:

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

The NC/SO Counties were partially compliant on one substandard of Standard 1: Substandard 2 (RY 2010).

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

Coordination and Continuity of Care

All of the CCBH Counties were non-compliant with Coordination and Continuity of Care due to non-compliance with two substandards of PEPS Standard 28.

PEPS Standard 28: See Standard description and non-compliant substandard determination under Availability of Services (Access to Care) above.

Coverage and Authorization of Services

All of the CCBH Counties were partially compliant with Coverage and Authorization of Services due to non-compliance with two substandards of PEPS Standard 28 and partial compliance with Standard 72, Substandard 1.

PEPS Standard 28: See Standard description and non-compliant substandard determination under Availability of Services (Access to Care) above.

PEPS Standard 72: Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county child and youth agency for children in substitute care. The denial note includes: a) specific reason for denial, b) service approved at a lesser rate, c) service approved for a lesser amount than requested, d) service approved for shorter duration than requested, e) service approved using a different service or Item than requested and description of the alternate service, if given, f) date decision will take effect, g) name of contact person, h) notification that member may file a grievance and/or request a DPW Fair Hearing, and i) if currently receiving services, the right to continue to receive services during the grievance and/or DPW Fair Hearing process.

Substandard 1: Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Practice Guidelines

All of the CCBH Counties were partially compliant with Practice Guidelines due to partial compliance with a substandard of PEPS Standard 28.



PEPS Standard 28: See Standard description and non-compliant substandard determination under Availability of Services (Access to Care) above.

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 County/BH MCO's compliance with regulations found in Subpart F. Table 1.4 presents the findings by categories consistent with the regulations.

Table 1.4 Compliance with Federal and State Grievance System Standards

Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All CCBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 3 substandards, partially compliant on 5 substandards and non-compliant on 2 substandards.
General Requirements 438.402	Partial		All CCBH Counties	14 substandards were crosswalked to this category. Each County was evaluated on 13 substandards, compliant on 6 substandards, partially compliant on 5 substandards and non-compliant on 2 substandards.
Notice of Action 438.404	Partial		All CCBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 9 substandards and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All CCBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 3 substandards, partially compliant on 5 substandards and non-compliant on 2 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All CCBH Counties	11 substandards were crosswalked to this category. Each County was evaluated on 10 substandards, compliant on 3 substandards, partially compliant on 5 substandards and non-compliant on 2 substandards.



Federal and State Grievance System Standards				
Subpart F: Categories	MCO Compliance Status	By County		Comments
		Fully Compliant	Partially Compliant	
Expedited Appeals Process 438.410	Partial		All CCBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 2 substandards and partially compliant on 3 substandards.
Information to Providers & Subcontractors 438.414	Partial		All CCBH Counties	2 substandards were crosswalked to this category. Each County was evaluated on 2 substandards, compliant on 1 substandard and partially compliant on 1 substandard.
Recordkeeping and Recording Requirements 438.416	Compliant	All CCBH Counties		Compliant as per 2012 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial		All CCBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 2 substandards and partially compliant on 3 substandards.
Effectuation of Reversed Resolutions 438.424	Partial		All CCBH Counties	6 substandards were crosswalked to this category. Each County was evaluated on 5 substandards, compliant on 2 substandards and partially compliant on 3 substandards.

There are 10 categories in the Federal and State Grievance System Standards. CCBH was compliant on one and partially compliant on nine categories. The category Recordkeeping and Recording Requirements was compliant as per the 2012 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.

For this review, 78 substandards were crosswalked to Federal and State Grievance System Standards for all 35 Counties associated with CCBH. Each County was evaluated on 70 substandards, compliant on 31 substandards, partially compliant on 31 substandards and non-compliant on 8 substandards. Eight substandards were not scheduled or not applicable for evaluation for RY 2012. 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.

Each County was partially compliant with five of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with two substandards and non-compliance with two substandards within PEPS Standard 68.



PEPS Standard 68: Complaint (and BBA Fair Hearing) rights and procedures are made known to Independent Enrollment Assistance Program (IEAP), members, BH MCO staff, and the provider network through manuals, training, handbooks, etc.

All of the CCBH Counties were partially compliant on two substandards of Standard 68: Substandard 1 and 4 (RY 2012).

Substandard 1: Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the compliant rights and procedures are made known to members, BH-MCO staff and the provider network.

Substandard 4: 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.

All of the CCBH Counties were non-compliant on two substandards of Standard 68: Substandard 3 and 5 (RY 2012).

Substandard 3: Complaint 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 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.

Each County was partially compliant with eight of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with two substandards within PEPS Standard 71.

PEPS Standard 71: Grievance and DPW Fair Hearing rights and procedures are made known to Enrollment Assistance Program (EAP), members, BH MCO staff and the provider network through manuals, training, handbooks, etc.

All of the CCBH Counties were partially compliant on two substandards of Standard 71: Substandards 3 and 4 (RY 2012).

Substandard 3: 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 4: Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.

Each County was partially compliant with eight of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with two substandards within PEPS Standard 72.

PEPS Standard 72: See Standard description and partially compliant substandard determination under Coverage and Authorization of Services on page 15 of this report.



II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, primary contractors (i.e., the Counties), along with the responsible subcontracted entities (i.e., BH MCOs), are required to conduct a minimum of two focused studies per year. The Counties and BH MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2013 for 2012 activities.

A new EQR PIP cycle began for BH MCOs and Counties in 2008. For this PIP cycle, OMHSAS again selected Follow-Up After Hospitalization for Mental Illness (FUH) as the PIP study topic to meet the EQR requirement. OMHSAS indicated that while some improvements were noted in the previous cycle, aggregate FUH rates remained below the previous OMHSAS-established benchmark of 90%. FUH for the Medicaid Managed Care (MMC) population continues to be an area of interest for OMHSAS.

The 2013 EQR is the tenth review to include validation of PIPs. With this PIP cycle, all BH MCOs/Counties share the same baseline period and timeline. To initiate the PIP cycle in 2008, 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, remeasurement, and sustained improvement. Direction was given to the BH MCOs/Counties with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness.

The BH MCOs are required by OMHSAS to submit their projects using the National Committee for Quality Assurance (NCQA™) Quality Improvement Activity (QIA) form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

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

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on the EQR of Medicaid MCOs issued on January 24, 2003. IPRO's review evaluates each project against nine review elements:

1. Project Topic, Type, Focus Area
2. Topic Relevance
3. Quality Indicators
4. Baseline Study Design and Analysis
5. Baseline Study Population
6. Interventions Aimed at Achieving Demonstrable Improvement
7. Demonstrable Improvement
- 1S. Subsequent or Modified Interventions
- 2S. Sustained Improvement

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last two relate 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. 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.

Review Element Designation/Weighting

For each review element, the assessment of compliance is determined through the weighted responses to each review item. 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
Full	Met or exceeded the element requirements	100%
Partial	Met essential requirements but is deficient in some areas	50%
Non-compliant	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 BH MCO's overall performance score for a PIP. The seven review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all seven demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance).

PIPs are also reviewed for the achievement of sustained improvement. This has a weight of 20%, for a possible maximum total of 20 points. The BH MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred through 2012. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule.

Point score allocation was modified for this PIP from the CMS protocol suggested points. Review Elements 1 (Project Title, Type, Focus Area) and 3 (Quality Indicators) were pre-determined by OMHSAS. Points for Element 1 were awarded based on BH MCO attendance on the Technical Assistance webinar conducted in October 2009 to discuss the new PIP cycle and the submission instructions for the project. Points will not be awarded for Element 3 because the indicators have been defined for the BH MCOs. These points have been reallocated to Elements 4 and 6. The point score reallocation for the FUH PIP is outlined in the scoring matrix in Table 2.2.

Table 2.2 Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Title, Type, Focus Area	5%
2	Topic Relevance	5%
3	Quality Indicators	0%
4	Baseline Study and Analysis	20%
5	Baseline Study Population and Baseline Measurement Performance	10%
6	Interventions Aimed at Achieving Demonstrable Improvement	20%
7	Demonstrable Improvement	20%
Total Demonstrable Improvement Score		80%



Review Element	Standard	Scoring Weight
1S	Subsequent or modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

Findings

As per the timeline distributed by OMHSAS for this review period, BH MCOs were required to submit information for the final review element of Sustained Improvement. CCBH submitted the required elements of the FUH PIP for review.

The project had previously received full credit for all elements through Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement. Of these, Topic Selection had been pre-determined by OMHSAS and pre-populated by IPRO into QIA forms that were sent to the BH MCOs in August 2009. As outlined in the PIP submission guidelines, CCBH received credit for Topic Selection by attending IPRO's Technical Assistance webinar held on October 5, 2009.

Follow-up After Hospitalization for Mental Illness

OMHSAS selected Follow-up After Hospitalization for Mental Illness as the topic for the PIP for all BH MCOs and Counties. OMHSAS again prioritized this as an area in need of improvement based on cumulative findings from multiple performance measures and data collection activities. In addition to defining the topic, OMHSAS defined the study indicator based on the Healthcare Effectiveness Data Information Set (HEDIS®) Follow-up After Hospitalization measure, for both the seven and 30-day rates. The study indicator utilizes HEDIS specifications to measure the percentage of discharges for members six years and older who were hospitalized for treatment of selected mental health disorders, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider on the date of discharge up to seven days [Quality Indicator (QI) 1] and 30 days (QI 2) after hospital discharge. Two additional indicators are also calculated, which utilize the HEDIS specifications outlined above, and include additional Pennsylvania service codes to define ambulatory or day/night treatment for both the seven and 30-day rates (called QIs A and B, respectively). All indicators are updated annually as necessary to reflect any changes to HEDIS technical specifications. In addition, the PA-specific indicators (QIs A and B) are reviewed on an annual basis by OMHSAS, the Counties and BH MCOs for consideration of inclusion of additional codes. OMHSAS previously determined that the rates calculated for Measurement Year (MY) 2008 using these four indicators are to be used as baseline measurements for all Counties/BH MCOs for the current PIP study cycle.

The rationale previously provided for this activity selection included information regarding the BH MCO's demographics, national research, and the BH MCO's root cause analysis. Referencing literature discussed in the IPRO MY 2008 Follow Up after Hospitalization for Mental Illness report, CCBH indicated that missed appointments are more frequent in those under age 25, and that racial disparities may exist for follow-up. CCBH provided corresponding demographic statistics for the BH MCO's membership, noting that 35% of the BH MCO's members are in the 5-19 age group, 17% are in the 20-34 age group, and 18% identify as African American. CCBH also noted that a total of 12% of the BH MCO's members in treatment have co-occurring mental health and substance abuse disorders. CCBH proposed that these populations, especially those with co-occurring disorders, are at risk for hospitalization and readmission.

CCBH also discussed its review of a number of research articles. CCBH began by stating that published research extensively documents the risk of poor treatment outcomes associated with inadequate treatment follow up after an inpatient mental health hospitalization, and that research indicates that individuals who do not have an outpatient appointment after discharge are two times more likely to be re-hospitalized in the same year than individuals who keep at least one outpatient appointment. Further, CCBH referenced research indicating that stabilization is sustained over time for individuals who keep an outpatient appointment, and other studies that found a relationship between the length of time between



discharge and the first appointment, noting that longer intervals are associated with a higher rate of missed appointments. CCBH cited additional research that found that the strongest predictor of keeping a follow-up appointment within seven and 30 days was receiving clinical treatment in the month before admission. Conversely, CCBH discussed a number of articles that outlined several factors associated with decreased adherence with follow-up appointments. CCBH observed that African American individuals, individuals discharged against medical advice, and individuals with co-occurring substance use disorders appear to be less likely to follow-up within seven and 30 days and therefore more likely to experience poor treatment outcomes. Other factors cited by the BH MCO as related to decreased adherence were: legal status at discharge, poor family support systems, not having an established outpatient clinician, persistent mental illness, having had no prior psychiatric hospitalizations, and having a longer length of stay.

Additionally, CCBH included a discussion of the MCO-conducted root cause analysis, which the BH MCO indicated was initiated to more fully understand the mechanisms influencing whether members kept their initial follow-up appointments after discharge from an inpatient stay and interventions that can address these issues. As a result of the analysis, CCBH observed that: 1) inpatient providers do not make discharge planning an integral part of the hospital stay, 2) inpatient providers are not always aware of the variety of treatment options available to members, 3) maintaining correct member information is difficult, and 4) it is difficult to balance the member's right to choose his/her own recovery plan as it may conflict with ambulatory follow up treatment. Following the analysis, CCBH developed action plans for addressing these issues.

Baseline results were calculated in 2009 for the period January 1, 2008 through December 31, 2008 and were presented along with analysis that would lead to interventions initiated in late 2009. The baseline results indicated a rate of 47.2% for QI 1 (HEDIS – seven days), 68.8% for QI 2 (HEDIS – 30 days), 60.3% for QI A (PA-Specific – seven days), and 76.6% for QI B (PA-Specific – 30 days). All rates fell below the MCO's goal of 90%. CCBH noted that the MCO's goal of 90% was adopted to match the benchmark established by OMHSAS for all BH MCOs. Following baseline, performance rates were analyzed at each individual County's Quality and Care Management Committees (QCMCs), as well as in aggregate at an internal workgroup composed of representatives from CCBH's Senior Management, Quality, and Clinical Departments, Consumer and Provider representatives. As per CCBH, barriers were derived from analysis at the individual QCMCs, the internal workgroup, company-wide outreach intervention efforts, as well as County Member Advisory Committees, Family Advisory Committees and Provider Advisory Committees. The BH MCO noted that performance rates are evaluated quarterly in order to more quickly identify trends and implement interventions in a timelier manner. As a result of these analyses, CCBH outlined numerous barriers at the BH MCO, member, and provider levels.

CCBH implemented numerous Interventions Aimed at Achieving Demonstrable Improvement, some of which had been previously implemented in 2008 and remained ongoing, and several that were implemented following baseline. CCBH implemented interventions to address barriers at the BH MCO, provider, and member levels. Some examples included: 1) medical record reviews of high volume inpatient providers to assess if providers educate members regarding follow-up, 2) collaboration with the Department of Human Services to communicate a child/adolescent member's shelter placement assignment within 24 hours to Care Management to ensure service coordination, 3) collaboration with the physical health (PH) MCO to coordinate care for those with physical and behavioral health diagnoses, 4) increased rates to outpatient service, certified peer specialists, and service coordination providers, 5) expansion of the BH MCO's mobile medication services in rural parts of the network to assist members in adhering to medication use, address barriers that may otherwise prevent medication adherence, and help members learn to self-manage their medications, 6) Annual Provider Benchmarking reports sent to all high volume providers with individualized ambulatory follow up data to inform providers about their follow up rates and compare them to provider network averages, which were enhanced to additionally target underperforming providers for meetings with BH MCO clinical staff, and 7) expansion of the Enhanced Clinical Case Management program, which blends Intensive Case Management and Mobile Outpatient services to better address the needs of members who have difficulty attending traditional post-discharge care services, or who may require intensive in-home or community support to successfully engage aftercare services.



Remeasurement results calculated in 2011 for January 1, 2010 through December 31, 2010 were presented, with comparisons of MY 2010 rates against the baseline rates and against the goal. Rates increased for all four indicators, and Demonstrable Improvement was achieved. QI 1 increased to 51.3%, QI 2 increased to 73.2%, QIA increased to 62.5%, and QIB increased to 78.9%. All rates remained below the goal of 90%. The validated performance rates for MY 2010 were analyzed at each individual county's Quality and Care Management Committees (QCMC) as well as in aggregate at an internal workgroup. CCBH noted that barriers continue to be identified from analysis at the individual QCMCs, the internal workgroup, company-wide Outreach intervention efforts, as well as County Member Advisory Committees, Family Advisory Committees and Provider Advisory Committees. CCBH noted that the MCO also monitors a similar measure on a quarterly basis in order to more quickly identify trends and implement interventions in a timelier manner, and that many of the previously identified barriers continue to remain relevant. To address these issues, the MCO conducted a series of focus groups with staff at four inpatient facilities and members across the network regarding current and optimal discharge activities to improve timely follow-up. Several themes emerged across the focus groups about activities designed to improve follow-up care, including: 1) Engagement of members and their support networks in the discharge process, 2) Member treatment preferences, 3) Member treatment expectations, 4) Members' education about the mental health system, and 5) Staff knowledge regarding outpatient treatment options.

CCBH noted that the findings from the focus groups were used to inform improvements to the interventions for 2011. Some of the previous interventions remained ongoing. Additionally, the MCO included a number of new interventions and/or modifications to existing interventions. Some of these subsequent interventions included: 1) providers of Behavioral Health Rehabilitation Services ((BHRS) Brief Treatment were offered enhanced reimbursement for providing immediate access to services to approved children, including those discharged from inpatient units, 2) members with long inpatient stays were identified in order to focus on barriers to discharge and enhance discharge planning, 3) meetings were initiated with providers based on underperformance on Provider Benchmarking Ambulatory Follow-Up data, volume of members, and previous performance, 4) the MCO expanded mobile and site based Psych Rehab, peer specialists, telepsychiatry, and forensic case management services in rural northern counties, 5) acute case managers were trained on engagement and linkage services, 6) a walk-in crisis center was opened in a rural area to increase access to services, 7) the MCO's care managers began participating in a weekly housing meeting with a large county to identify members ready for discharge to placements and prioritize referrals, 8) the Consent to Release form was revised to allow for MCOs to communicate with each other, 9) quarterly meetings were initiated with Single County Authorities to discuss barriers faced in providing smooth transitions for members back into the community, 10) eight new "discharge planning" Blended Service Coordinator positions were added across the network. CCBH received full credit for Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.

As indicated by the DPW timeline, Sustained Improvement was evaluated in 2013, based on activities conducted in 2012 to assess performance in 2011. Remeasurement results calculated in 2013 for January 1, 2011 through December 31, 2011 were presented, with comparisons against the baseline rates and against the goal. Rates increased over baseline for three of four indicators, and Sustained Improvement was achieved. QI 1 increased to 49.3%, QI 2 increased to 71.7% and QIB increased to 77.6%. All rates remained below the goal of 90%.

CCBH received full credit for the elements of the study evaluated that reflected activities in 2012 (Sustained Improvement) and received a total score of 100 for this project.



**Table 2.3 PIP Scoring Matrix:
Follow-up After Hospitalization for Mental Illness**

Review Element	Compliance Level	Scoring Weight	Final Points Score
1. Project Title, Type, Focus Area	Full	5%	5
2. Topic Relevance	Full	5%	5
3. Quality Indicators	Full	0%	0
4. Baseline Study and Analysis (Calendar Year (CY) 2008, reported in CY 2009)	Full	20%	20
5. Baseline Study Population and Baseline Measurement Performance (CY 2008)	Full	10%	10
6. Interventions Aimed at Achieving Demonstrable Improvement (CY 2009 through 06/2010)	Full	20%	20
7. Demonstrable Improvement (CY 2010, reported in 2011)	Full	20%	20
Total Demonstrable Improvement Score			80
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Full	5%	5
2S. Sustained Improvement (CY 2011, reported in 2012)	Full	15%	15
Total Sustained Improvement Score			20
Overall Project Performance Score			100

**Table 2.4 PIP Year Over Year Results:
Follow-up After Hospitalization for Mental Illness**

Project	2008	2009/2010	2010	2010/2011	Comparison Benchmark for Review Year
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge (QI 1)	47.2%	NA	51.3% ¹	49.3% ²	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	68.8%	NA	73.2% ¹	71.7% ²	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	60.3%	NA	62.5% ¹	60.3%	90%
PA-Specific Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	76.6%	NA	78.9% ¹	77.6% ²	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	

¹ Indicates Demonstrable Improvement, eligible for subsequent evaluation of Sustained Improvement.

² Indicates Sustained Improvement



III: PERFORMANCE MEASURES

In 2013, OMHSAS and IPRO conducted two EQR studies. Both the Follow-up After Hospitalization for Mental Illness and Readmission within 30 Days of Inpatient Psychiatric Discharge studies were re-measured.

Follow-up After Hospitalization for Mental Illness

This performance measure assessed the percentage of discharges for members six 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 seven and 30 days after hospital discharge. The measure continued to be of interest to OMHSAS for the purposes of comparing County, BHHC, and BH MCO rates to available national benchmarks and to prior years' rates.

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

The last major change to the PA-specific measures was in MY 2006. Codes added to the measures as per suggestions from OMHSAS, the Counties, and BH MCOs changed the measures substantially, and rates for these indicators were no longer comparable to those from preceding measurement years. Consequently, these indicators were renamed to QI A and QI B, respectively. As these indicators represented a significant deviation from HEDIS measure specifications, comparisons to HEDIS rates were not made. In addition, for MY 2006 the follow-up measure was collected for the newly implemented HealthChoices Northeast Counties, and these Counties were asked to collect data for the six-month time frame that they were in service for 2006.

For MY 2007, all PA local codes previously mapped to standard CPT and HCPCS codes as per HIPAA requirements were retired and removed. Additionally, the measure was initiated for the 23 North/Central State Option Counties implemented in January 2007. As with the Northeast Counties for MY 2006, the North/Central County Option Counties were asked to collect data for the six-month time frame that they were in service for 2007.

For MY 2008, two procedure codes to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH MCOs. Additionally, as requested by OMHSAS, the MY 2008 findings by age were presented as three cohorts: Ages 6-20 years, Ages 21-64 years, and Ages 65 years and over. The Ages 21-64 years cohort was reported as two age ranges (Ages 21-59 years and Ages 60-64 years) in prior measurements.

For MY 2009, indicators in the study had few changes. As requested by OMHSAS, all data analyses by region were removed, since the regional characteristics had become increasingly geographically diverse and the associated Counties are non-contiguous as the HealthChoices BH Program expanded beyond the initial legacy regions over the years of re-measurement.

For MY 2010, indicators had very few changes based on the HEDIS 2011 Volume 2: Technical Specifications. One revenue code was removed from the criteria to identify non-acute care exclusions.

For MY 2011, there was one minor change to the HEDIS specifications. An additional place of service code was added to the numerator specifications. There was no narrative report produced for MY 2011;



however, aggregate and demographic rates were provided, and recommendations were submitted to OMHSAS.

For MY 2012, indicators again had minor changes based on the HEDIS 2013 Volume 2: Technical Specifications. A clarification was added to only use facility claims, not professional claims, to identify discharges. As requested by OMHSAS, analysis by BHHC was added.

Measure Selection and Description

In accordance with DPW 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 six 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 seven 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 67 Counties participating in the MY 2012 study.

Eligible cases were defined as those members in the HealthChoices 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, 2012;
- A principal ICD-9-CM diagnosis code indicating one of the specified mental health disorders;
- Six 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, 2012, 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 1st, 2012. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2013 methodology for the Follow-up After Hospitalization for Mental Illness measure.

I: HEDIS Indicators

Quality Indicator 1 (QI 1): Follow-up After Hospitalization for Mental Illness within Seven 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 seven 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.

II: PA-Specific Indicators

Quality Indicator A (QI A): Follow-up After Hospitalization for Mental Illness within Seven 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 seven 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 (WHO) in 2008, mental illnesses and mental disorders represent six 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)ⁱ. 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^{ii,iii} such as obesity, cardiovascular diseases and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns^{iv,v}, reduced use of preventive services^{vi} and substandard medical care that they receive^{vii,viii,ix}. Moreover, these patients are five times more likely to become homeless than those without these disorders^x. On the whole, serious mental illnesses account for more than 15 percent of overall disease burden in the U.S.^{xi}, 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^{xii}. 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^{xiii}. As noted in its 2007 *The State of Health Care Quality* report by the NCQA, appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses, and the likelihood of recurrence^{xiv}. An outpatient visit within at least 30 days (ideally seven 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 identify



complications early on to avoid more inappropriate and costly use of hospitals and emergency departments^{xv}. 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^{xvi}. And 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^{xvii}.

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a longstanding concern of behavioral health care systems, with some researchers having estimated that 40 to 60 percent of patients fail to connect with an outpatient clinician^{xviii}. Research has demonstrated that patients who do not have an outpatient appointment after discharge were two times more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment^{xix}. 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^{xx}. 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^{xxi}. Patients with higher functioning in turn had significantly lower community costs, and improved provider continuity was associated with lower hospital^{xxii} and Medicaid costs^{xxiii}.

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^{xxiv}. 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 County 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

Performance goals were set for this review year, as had been done since the implementation of this measure, at the OMHSAS designated gold standard of 90% for all measures. In addition, the HEDIS measures were compared to industry benchmarks, in that the aggregate and BH MCO indicator rates were compared to the *HEDIS 2013 Audit Means, Percentiles and Ratios*. These benchmarks contained means, 10th, 25th, 50th (median), 75th and 90th percentiles, and the enrollment ratios for nearly all HEDIS measures. There were tables published by product line (i.e., Commercial, Medicaid, and Medicare). The appropriate Medicaid benchmarks available for the measurement year were used for comparison. As indicated previously, the PA-specific measures were not comparable to these industry benchmarks.

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 benchmarks. As a result of this discussion, OMHSAS adopted HEDIS benchmarks as the goals for the HEDIS indicators. The 3-year OMHSAS goal is to achieve the 75th percentile for ages 6-64, based on the annual HEDIS published benchmarks for 7-day and 30-day FUH. Additionally, HEDIS benchmarks for the 7- and 3-day FUH indicators have been adopted as the



benchmarks for determining the requirement for a root cause analysis for these indicators. Beginning with MY 2012 performance, and as noted in Section V of this report, rates for the HEDIS FUH 7- and 30-day indicators that fall below the 75th percentile benchmarks for each of these respective indicators will result in a request for a root cause analysis. Following MY 2012, performance goals will be established for each BH MCO, County or primary BHHC based on the HEDIS published benchmarks for the previous year.

Data Analysis

The quality indicators were defined as rates, based on a numerator and a denominator. The denominator equaled the number of discharges eligible for the quality indicator, while the numerator was the total number of members for which the particular event occurred. The overall, or aggregate, performance rate for each indicator was the total numerator divided by the total denominator, which represented the rate derived from the total population of discharges that qualified for the indicator. The aggregate rate represented the rate derived from the total population of members that qualified for the indicator (i.e., the aggregate value). Year-to-year comparisons to MY 2011 data were provided where applicable. 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-ratio. Statistically significant differences (SSD) at the .05 level between groups are noted, as well as the percentage point difference (PPD) between the rates.

Findings

BH MCO and County Results

The results are presented at the BH MCO and County level when multiple Counties 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 Counties with the same contracted BH MCO). The County-specific rates were calculated using the numerator and denominator for that particular County. For each of these rates, the 95% Confidence Interval (CI) was reported. Both the HealthChoices BH MCO Average and HealthChoices County Average rates were also calculated for the indicators.

BH MCO-specific rates were compared to the HealthChoices BH MCO Average to determine if they were statistically significantly above or below that value. Whether or not a BH MCO performed statistically significantly above or below the average was determined by whether or not that BH MCO's 95% CI included the HealthChoices BH MCO Average for the indicator. Statistically significant BH MCO differences are noted.

County-specific rates were compared to the HealthChoices County Average to determine if they were statistically significantly above or below that value. Whether or not a County performed statistically significantly above or below the average was determined by whether or not that County's 95% CI included the HealthChoices County Average for the indicator. Statistically significant county-specific differences are noted.

Table 3.1 MY 2012 HEDIS Indicator Rates with Year-to-Year Comparisons

	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	16,978	35,972	47.2%	46.7%	47.7%	46.7%	48.2%	46.1%	1.1	YES
CCBH	6,635	13,351	49.7%	48.8%	50.6%			49.3%	0.4	NO
Adams	49	96	51.0%	40.5%	61.6%			50.0%	1.0	NO



	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Allegheny	1,726	3,525	49.0%	47.3%	50.6%			49.5%	-0.5	NO
Berks	625	1,081	57.8%	54.8%	60.8%			55.0%	2.8	NO
Bradford	94	181	51.9%	44.4%	59.5%			53.5%	-1.5	NO
Cameron	8	24	33.3%	12.4%	54.3%			22.7%	10.6	NO
Carbon	101	236	42.8%	36.3%	49.3%			42.4%	0.4	NO
Centre	131	250	52.4%	46.0%	58.8%			49.6%	2.8	NO
Chester	362	686	52.8%	49.0%	56.6%			51.0%	1.8	NO
Clarion	70	140	50.0%	41.4%	58.6%			41.1%	8.9	NO
Clearfield	201	374	53.7%	48.6%	58.9%			50.4%	3.3	NO
Columbia	88	182	48.4%	40.8%	55.9%			57.0%	-8.7	NO
Elk	54	108	50.0%	40.1%	59.9%			53.8%	-3.8	NO
Erie	447	1,079	41.4%	38.4%	44.4%			38.9%	2.6	NO
Forest	9	20	45.0%	20.7%	69.3%			22.2%	22.8	NO
Huntingdon	56	126	44.4%	35.4%	53.5%			44.4%	0.0	NO
Jefferson	116	238	48.7%	42.2%	55.3%			37.8%	11.0	NO
Juniata	20	44	45.5%	29.6%	61.3%			63.5%	-18.0	NO
Lackawanna	408	693	58.9%	55.1%	62.6%			55.7%	3.1	NO
Luzerne	573	1,066	53.8%	50.7%	56.8%			52.8%	1.0	NO
McKean	49	132	37.1%	28.5%	45.7%			43.5%	-6.4	NO
Mifflin	131	232	56.5%	49.9%	63.1%			46.1%	10.4	NO
Monroe	136	288	47.2%	41.3%	53.2%			49.4%	-2.2	NO
Montour	39	54	72.2%	59.3%	85.1%			66.1%	6.1	NO
Northumberland	137	267	51.3%	45.1%	57.5%			46.9%	4.4	NO
Pike	32	66	48.5%	35.7%	61.3%			36.1%	12.4	NO
Potter	21	44	47.7%	31.8%	63.6%			44.4%	3.3	NO
Schuylkill	246	574	42.9%	38.7%	47.0%			42.6%	0.2	NO
Snyder	38	65	58.5%	45.7%	71.2%			53.9%	4.5	NO
Sullivan	4	18	22.2%	0.2%	44.2%			63.6%	-41.4	NO
Susquehanna	30	53	56.6%	42.3%	70.9%			52.2%	4.4	NO
Tioga	43	97	44.3%	33.9%	54.7%			57.5%	-13.2	NO
Union	45	70	64.3%	52.4%	76.2%			71.6%	-7.4	NO
Warren	66	171	38.6%	31.0%	46.2%			50.7%	-12.1	NO
Wayne	52	106	49.1%	39.1%	59.0%			59.6%	-10.5	NO
Wyoming	32	55	58.2%	44.2%	72.1%			47.5%	10.7	NO
York	396	910	43.5%	40.2%	46.8%			40.0%	3.5	NO
Q1 2										



	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	24,388	35,972	67.8%	67.3%	68.3%	67.4%	72.5%	67.0%	0.8	NO
CCBH	9,576	13,351	71.7%	71.0%	72.5%			71.7%	0.0	NO
Adams	70	96	72.9%	63.5%	82.3%			76.8%	-3.9	NO
Allegheny	2,365	3,525	67.1%	65.5%	68.7%			69.0%	-1.9	NO
Berks	818	1,081	75.7%	73.1%	78.3%			75.2%	0.5	NO
Bradford	127	181	70.2%	63.2%	77.1%			71.9%	-1.7	NO
Cameron	18	24	75.0%	55.6%	94.4%			50.0%	25.0	NO
Carbon	161	236	68.2%	62.1%	74.4%			66.9%	1.4	NO
Centre	196	250	78.4%	73.1%	83.7%			76.9%	1.5	NO
Chester	500	686	72.9%	69.5%	76.3%			73.0%	-0.1	NO
Clarion	112	140	80.0%	73.0%	87.0%			73.2%	6.8	NO
Clearfield	301	374	80.5%	76.3%	84.6%			77.8%	2.6	NO
Columbia	123	182	67.6%	60.5%	74.7%			73.0%	-5.4	NO
Elk	85	108	78.7%	70.5%	86.9%			80.2%	-1.5	NO
Erie	735	1,079	68.1%	65.3%	70.9%			64.6%	3.5	NO
Forest	15	20	75.0%	53.5%	96.5%			44.4%	30.6	NO
Huntingdon	96	126	76.2%	68.4%	84.0%			81.0%	-4.8	NO
Jefferson	179	238	75.2%	69.5%	80.9%			70.8%	4.4	NO
Juniata	33	44	75.0%	61.1%	88.9%			84.6%	-9.6	NO
Lackawanna	544	693	78.5%	75.4%	81.6%			77.9%	0.6	NO
Luzerne	788	1,066	73.9%	71.2%	76.6%			75.0%	-1.1	NO
McKean	99	132	75.0%	67.2%	82.8%			71.4%	3.6	NO
Mifflin	187	232	80.6%	75.3%	85.9%			74.3%	6.3	NO
Monroe	218	288	75.7%	70.6%	80.8%			73.0%	2.7	NO
Montour	48	54	88.9%	79.6%	98.2%			79.7%	9.2	NO
Northumberland	199	267	74.5%	69.1%	79.9%			68.8%	5.7	NO
Pike	50	66	75.8%	64.7%	86.9%			65.3%	10.5	NO
Potter	34	44	77.3%	63.8%	90.8%			75.0%	2.3	NO
Schuylkill	410	574	71.4%	67.6%	75.2%			67.6%	3.9	NO
Snyder	49	65	75.4%	64.1%	86.6%			68.4%	7.0	NO
Sullivan	11	18	61.1%	35.8%	86.4%			72.7%	-11.6	NO
Susquehanna	42	53	79.3%	67.4%	91.1%			73.9%	5.3	NO
Tioga	64	97	66.0%	56.0%	75.9%			76.4%	-10.4	NO
Union	58	70	82.9%	73.3%	92.4%			83.6%	-0.7	NO
Warren	123	171	71.9%	64.9%	79.0%			74.6%	-2.7	NO
Wayne	75	106	70.8%	61.6%	79.9%			81.8%	-11.1	NO



	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Wyoming	46	55	83.6%	73.0%	94.3%			67.5%	16.1	NO
York	597	910	65.6%	62.5%	68.7%			65.9%	-0.3	NO

Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

The MY 2012 HealthChoices aggregate rates were 47.2% for QI 1 and 67.8% for QI 2. The QI 1 rate was 1.1 percentage points above the MY 2011 rate which was a statistically significant difference. There was no statistically significant difference between the MY 2012 and MY 2011 QI 2 rates. CCBH's MY 2012 rate was 49.7% for QI 1 and 71.7% for QI 2. There were no statistically significant differences between the MY 2012 and MY 2011 rates for CCBH.

For MY 2012, CCBH's QI 1 rate of 49.7% was statistically significantly higher than the QI 1 HealthChoices BH MCO Average of 46.7% by 3.0 percentage points. CCBH's QI 2 rate of 71.7% was 4.3 percentage points above the QI 2 HealthChoices BH MCO Average of 67.4% which was not a statistically significant difference. Overall, CCBH's rates were the highest for QI 1 and QI 2 among the five BH MCOs evaluated in MY 2012.

As presented in Table 3.1, there were no statistically significant year over year differences between MY 2012 and MY 2011 QI 1 and QI 2 County rates. Figure 3.1 displays a graphical representation of the MY 2012 HEDIS follow-up rates for CCBH and its associated Counties. Figure 3.2 represents the individual CCBH Counties that performed statistically significantly above or below the MY 2012 QI 1 and QI 2 HealthChoices County Averages.

In MY 2012, eight CCBH Counties (Berks, Chester, Clearfield, Lackawanna, Luzerne, Mifflin, Montour, and Union) had QI 1 rates statistically significantly higher than the MY 2012 QI HealthChoices County Average of 48.2%, and six Counties (Erie, McKean, Schuylkill, Sullivan, Warren and York) performed statistically significantly below this average. MY 2012 rates for the remaining 22 CCBH Counties did not differ statistically significantly from the QI 1 HealthChoices County Average.

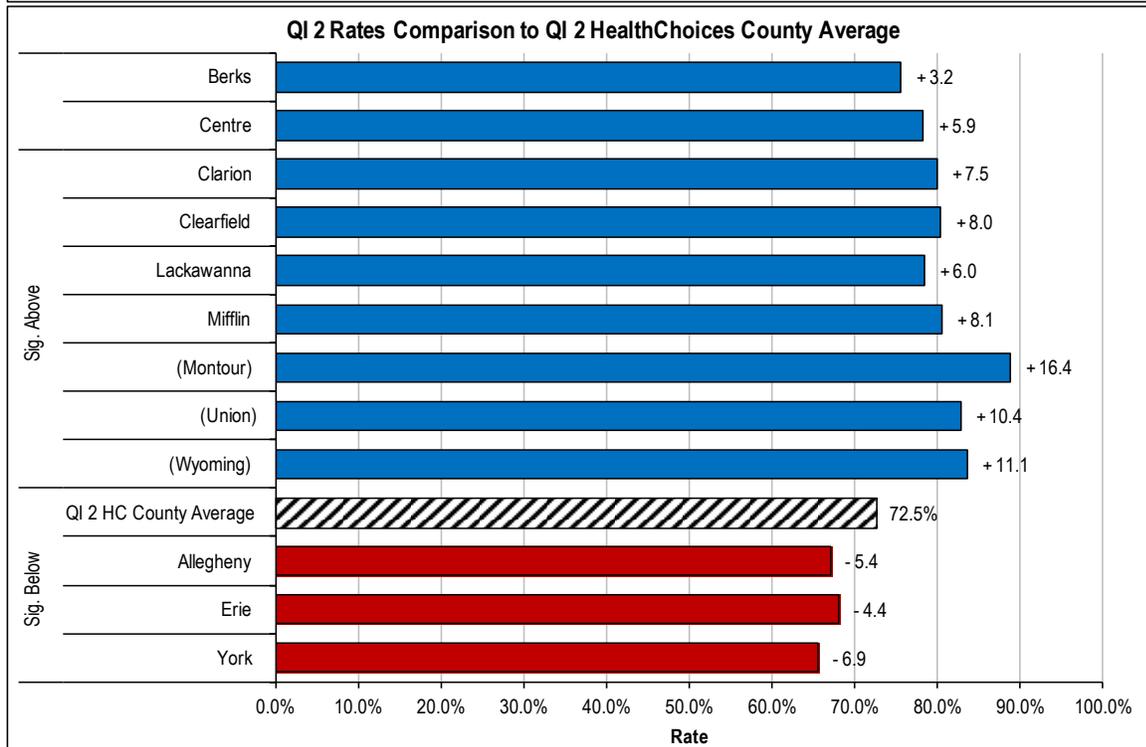
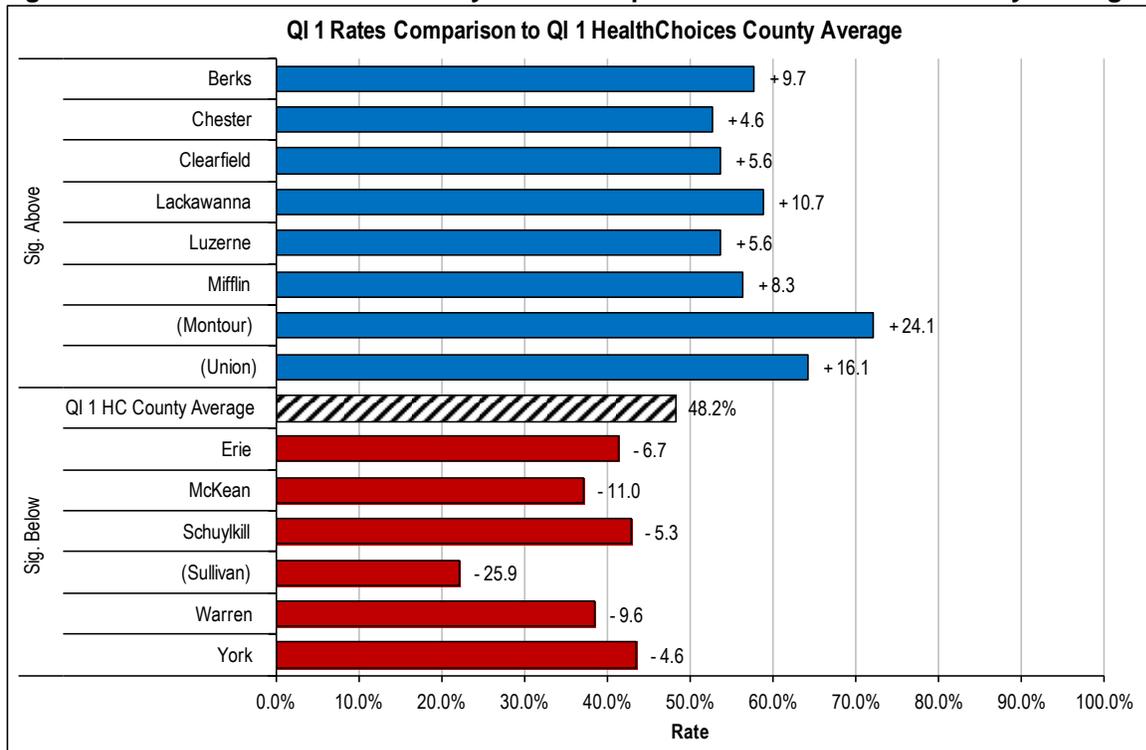
The HealthChoices County Average for QI 2 was 72.5% for MY 2012. Nine Counties (Berks, Centre, Clarion, Clearfield, Lackawanna, Mifflin, Montour, Union and Wyoming) performed statistically significantly above, while three Counties (Allegheny, Erie, and York) were statistically significantly below the MY 2012 QI 2 HealthChoices County Average. MY 2012 QI 2 rates for the remaining 24 CCBH Counties did not differ statistically significantly from the MY 2012 QI 2 HealthChoices County Average.

Figure 3.1 MY 2012 HEDIS Indicator Rates



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.

Figure 3.2 MY 2012 HEDIS County Rates Compared to HealthChoices County Average



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.



Table 3.2 MY 2012 PA-Specific Indicator Rates with Year-to-Year Comparisons

	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	21,096	35,972	58.7%	58.1%	59.2%	58.2%	59.3%	57.8%	0.8	YES
CCBH	8,153	13,351	61.1%	60.2%	61.9%			60.3%	0.8	NO
Adams	54	96	56.3%	45.8%	66.7%			56.3%	0.0	NO
Allegheny	2,171	3,525	61.6%	60.0%	63.2%			62.4%	-0.8	NO
Berks	721	1,081	66.7%	63.8%	69.6%			64.0%	2.7	NO
Bradford	111	181	61.3%	54.0%	68.7%			58.1%	3.3	NO
Cameron	13	24	54.2%	32.2%	76.2%			40.9%	13.3	NO
Carbon	116	236	49.2%	42.6%	55.7%			50.6%	-1.4	NO
Centre	162	250	64.8%	58.7%	70.9%			60.7%	4.1	NO
Chester	428	686	62.4%	58.7%	66.1%			61.7%	0.7	NO
Clarion	94	140	67.1%	59.0%	75.3%			50.9%	16.2	YES
Clearfield	264	374	70.6%	65.8%	75.3%			65.9%	4.7	NO
Columbia	105	182	57.7%	50.2%	65.1%			68.5%	-10.8	NO
Elk	66	108	61.1%	51.5%	70.8%			67.9%	-6.8	NO
Erie	613	1,079	56.8%	53.8%	59.8%			54.0%	2.8	NO
Forest	10	20	50.0%	25.6%	74.4%			22.2%	27.8	NO
Huntingdon	85	126	67.5%	58.9%	76.0%			65.9%	1.6	NO
Jefferson	165	238	69.3%	63.3%	75.4%			58.4%	11.0	YES
Juniata	30	44	68.2%	53.3%	83.1%			78.8%	-10.7	NO
Lackawanna	463	693	66.8%	63.2%	70.4%			63.3%	3.5	NO
Luzerne	669	1,066	62.8%	59.8%	65.7%			60.5%	2.3	NO
McKean	78	132	59.1%	50.3%	67.9%			64.3%	-5.2	NO
Mifflin	183	232	78.9%	73.4%	84.3%			64.9%	14.0	YES
Monroe	158	288	54.9%	48.9%	60.8%			57.1%	-2.3	NO
Montour	41	54	75.9%	63.6%	88.3%			74.6%	1.4	NO
Northumberland	162	267	60.7%	54.6%	66.7%			58.8%	1.8	NO
Pike	35	66	53.0%	40.2%	65.8%			43.1%	10.0	NO
Potter	24	44	54.6%	38.7%	70.4%			47.2%	7.3	NO
Schuylkill	314	574	54.7%	50.5%	58.9%			55.5%	-0.8	NO
Snyder	43	65	66.2%	53.9%	78.4%			63.2%	3.0	NO
Sullivan	7	18	38.9%	13.6%	64.2%			72.7%	-33.8	NO
Susquehanna	33	53	62.3%	48.3%	76.3%			58.7%	3.6	NO
Tioga	48	97	49.5%	39.0%	59.9%			63.2%	-13.7	NO
Union	47	70	67.1%	55.4%	78.9%			76.1%	-9.0	NO



	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Warren	95	171	55.6%	47.8%	63.3%			62.3%	-6.8	NO
Wayne	59	106	55.7%	45.7%	65.6%			67.7%	-12.0	NO
Wyoming	34	55	61.8%	48.1%	75.6%			47.5%	14.3	NO
York	452	910	49.7%	46.4%	53.0%			45.9%	3.8	NO
QI B										
HealthChoices	26,978	35,972	75.0%	74.6%	75.4%	74.8%	78.4%	74.8%	0.2	NO
CCBH	10,373	13,351	77.7%	77.0%	78.4%			77.5%	0.1	NO
Adams	72	96	75.0%	65.8%	84.2%			78.6%	-3.6	NO
Allegheny	2,665	3,525	75.6%	74.2%	77.0%			76.7%	-1.1	NO
Berks	872	1,081	80.7%	78.3%	83.1%			78.8%	1.9	NO
Bradford	137	181	75.7%	69.2%	82.2%			74.2%	1.5	NO
Cameron	19	24	79.2%	60.8%	97.5%			54.5%	24.6	NO
Carbon	172	236	72.9%	67.0%	78.8%			70.9%	1.9	NO
Centre	212	250	84.8%	80.1%	89.5%			81.8%	3.0	NO
Chester	531	686	77.4%	74.2%	80.6%			77.4%	0.0	NO
Clarion	122	140	87.1%	81.2%	93.0%			81.3%	5.9	NO
Clearfield	322	374	86.1%	82.5%	89.7%			85.4%	0.7	NO
Columbia	137	182	75.3%	68.7%	81.8%			81.0%	-5.7	NO
Elk	88	108	81.5%	73.7%	89.3%			86.8%	-5.3	NO
Erie	811	1,079	75.2%	72.5%	77.8%			73.6%	1.5	NO
Forest	17	20	85.0%	66.9%	100.0%			55.6%	29.4	NO
Huntingdon	105	126	83.3%	76.4%	90.2%			84.9%	-1.6	NO
Jefferson	203	238	85.3%	80.6%	90.0%			80.3%	5.0	NO
Juniata	38	44	86.4%	75.1%	97.6%			92.3%	-5.9	NO
Lackawanna	565	693	81.5%	78.6%	84.5%			81.8%	-0.3	NO
Luzerne	830	1,066	77.9%	75.3%	80.4%			77.7%	0.1	NO
McKean	113	132	85.6%	79.2%	92.0%			81.2%	4.4	NO
Mifflin	210	232	90.5%	86.5%	94.5%			81.7%	8.8	YES
Monroe	224	288	77.8%	72.8%	82.8%			77.6%	0.1	NO
Montour	48	54	88.9%	79.6%	98.2%			83.1%	5.8	NO
Northumberland	213	267	79.8%	74.8%	84.8%			78.8%	0.9	NO
Pike	52	66	78.8%	68.2%	89.4%			69.4%	9.3	NO
Potter	35	44	79.6%	66.5%	92.6%			77.8%	1.8	NO
Schuylkill	434	574	75.6%	72.0%	79.2%			75.8%	-0.1	NO
Snyder	50	65	76.9%	65.9%	87.9%			80.3%	-3.3	NO
Sullivan	14	18	77.8%	55.8%	99.8%			81.8%	-4.0	NO



	MY 2012						MY 2011	RATE COMPARISON MY 2012 to MY 2011		
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Susquehanna	43	53	81.1%	69.7%	92.6%			76.1%	5.0	NO
Tioga	70	97	72.2%	62.7%	81.6%			79.2%	-7.1	NO
Union	58	70	82.9%	73.3%	92.4%			85.1%	-2.2	NO
Warren	136	171	79.5%	73.2%	85.9%			81.2%	-1.6	NO
Wayne	76	106	71.7%	62.7%	80.7%			83.8%	-12.1	NO
Wyoming	48	55	87.3%	77.6%	97.0%			67.5%	19.8	YES
York	631	910	69.3%	66.3%	72.4%			68.7%	0.6	NO

The MY 2012 HealthChoices aggregate rates were 58.7% for QI A and 75.0% for QI B. The QI A rate was 0.8 percentage points above the MY 2011 rate which was a statistically significant difference. The QI B rate was comparable to (i.e., not statistically significantly different from) MY 2011 rate. CCBH's MY 2012 QI A rate was 61.1% and QI B rate was 77.7%. Both rates was comparable to (i.e., not statistically significantly different from) MY 2011.

For MY 2012, CCBH's QI A rate of 61.1% was statistically significantly higher than the MY 2012 QI A HealthChoices BH MCO Average of 58.7% by 2.9 percentage points. CCBH's MY 2012 QI B rate of 77.7% was comparable to (i.e., not statistically significantly different from) the MY 2012 QI B HealthChoices BH MCO Average of 74.8%. Overall, CCBH's rates were the highest for QI A and QI B among the five BH MCOs evaluated in MY 2012.

As presented in Table 3.2, the MY 2012 QI A rates for Clarion, Jefferson and Mifflin and Counties had statistically significant increases when compared to the prior year. For QI B, the rate for Mifflin and Wyoming Counties statistically significantly increased between MY 2011 and MY 2012. Year-to-year rate changes for the remaining Counties were not statistically significant.

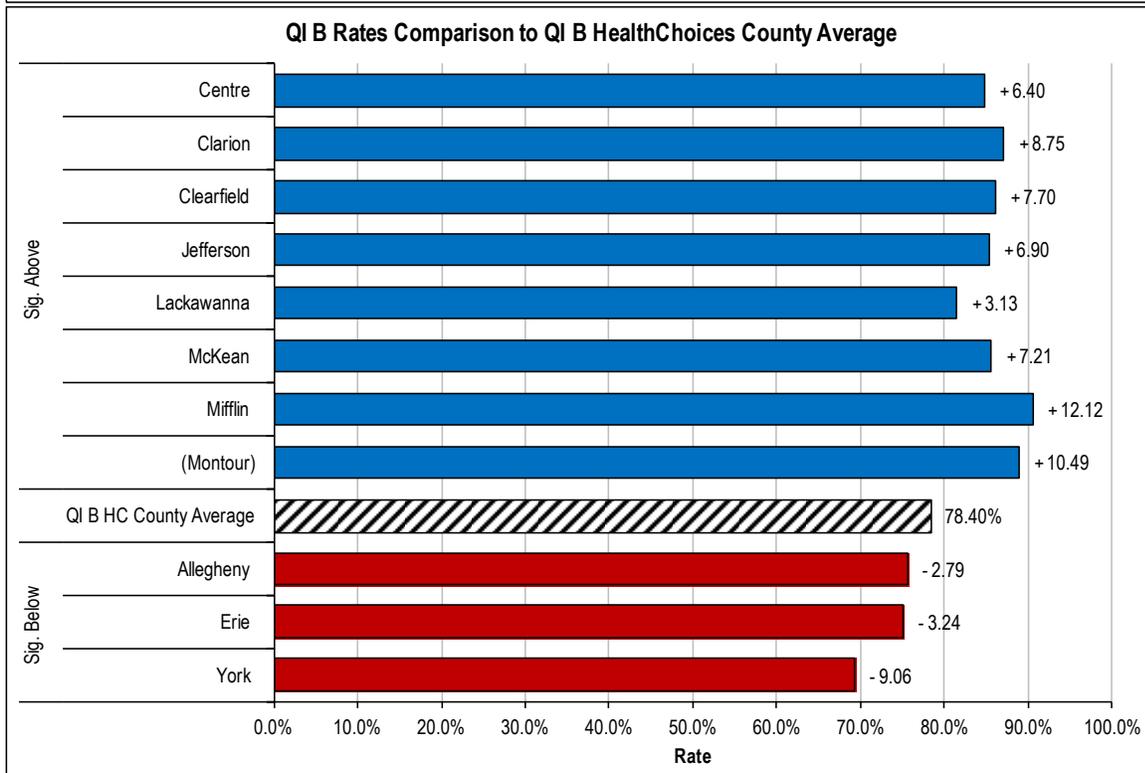
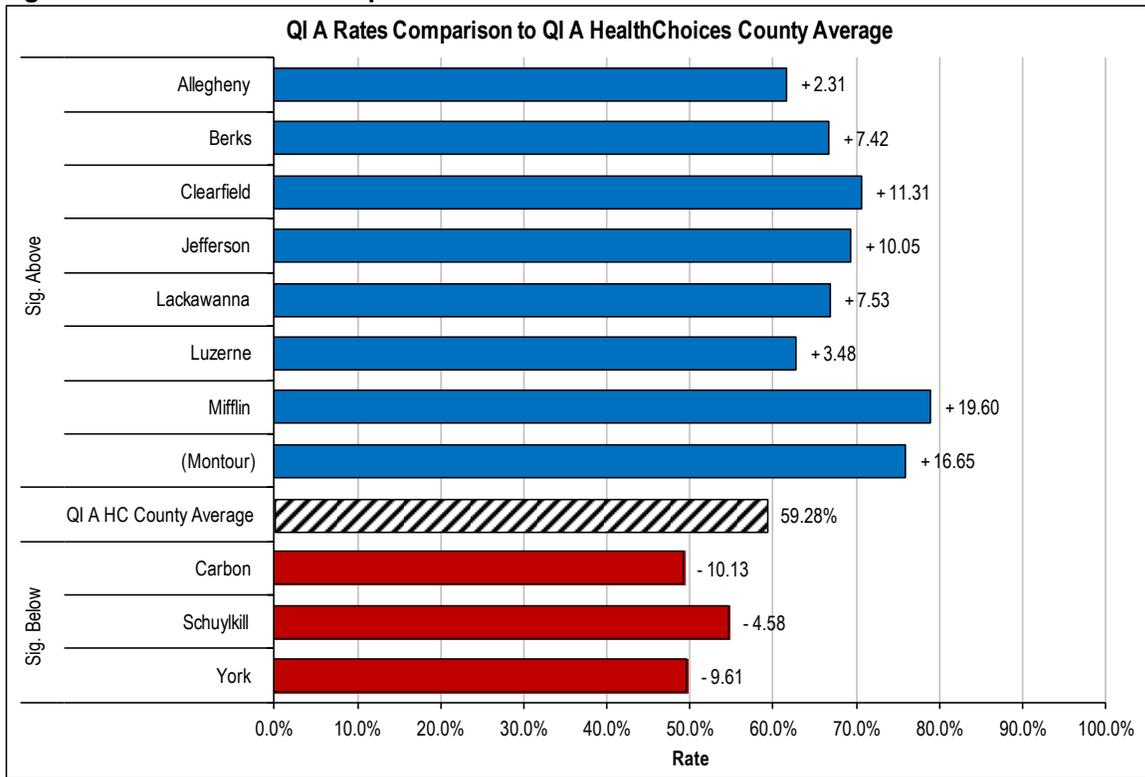
Figure 3.3 displays a graphical representation of the MY 2012 PA-specific follow-up rates for CCBH and its associated Counties. Figure 3.4 presents the individual CCBH Counties that performed statistically significantly above or below the MY 2012 QI A and QI B HealthChoices County Averages.

Figure 3.3 MY 2012 PA-Specific Indicator Rates



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.

Figure 3.4 MY 2012 PA-Specific Indicator Rates



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.



Comparison to HEDIS® Medicaid Benchmarks

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2013 Audit Means, Percentiles and Ratios* published by NCQA. The reference rates for national normative data contain means, 10th, 25th, 50th, 75th and 90th percentiles, and the enrollment ratios for nearly all HEDIS measures. There are tables by product lines (i.e., Commercial, Medicaid, and Medicare), so that the appropriate Medicaid benchmarks were used for comparison. NCQA's means and percentiles for each product line are generated annually using HMO, POS, and HMO/POS combined products from BH MCOs that underwent a HEDIS Compliance Audit™. Data were included from BH MCOs, regardless of whether the BH MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2013 Audit Means, Percentiles and Ratios* tables are based on data from the 2012 measurement year. The benchmark values for Medicaid are presented in Table 3.3.

Table 3.3 HEDIS 2013 Medicaid Benchmarks

MEDICAID	SUMMARY STATISTICS FOR RATES ACROSS MCOs					
	MEAN	10TH %ILE	25TH %ILE	MEDIAN	75TH %ILE	90TH %ILE
Follow-up After Hospitalization for Mental Illness – 7 Days	43.8	21.3	31.3	44.7	54.8	68.8
Follow-up After Hospitalization for Mental Illness – 30 Days	63.8	38.1	57.2	65.9	75.7	82.0

For MY 2012, the HealthChoices rates were 47.2 % for QI 1 and 67.8% for QI 2. As compared to the HEDIS 2013 (MY 2012) Medicaid benchmarks, both the QI 1 and QI 2 rates fell between the 50th and 75th percentiles. In previous benchmark comparisons for MY 2011, the HealthChoices rate for QI 1 fell between the 50th and 75th percentiles and the rate for QI 2 fell between the 25th and 50th percentiles.

When comparing the MY 2012 CCBH rates to the HEDIS 2013 benchmarks, the QI 1 rate of 49.7% fell between the 50th and 75th percentiles while MY 2012 the QI 2 rate of 71.7% fell between the 50th and 75th percentiles. When compared to the HEDIS 2012 benchmarks, CCBH's QI 1 rate of 49.3% and QI 2 rate of 71.7% fell between the 50th and 75th percentiles.

Conclusion and Recommendations

The study concluded that efforts should continue to be made to improve performance with regard to Follow-up After Hospitalization for Mental Illness particularly for those BH MCOs that performed below the HealthChoices BH MCO Average.

In response to the 2013 study, which included results for MY 2011 and MY 2012, the following general recommendations were made to all five participating BH MCOs:

Recommendation 1: The purpose of this re-measurement study is to inform OMHSAS, the Counties, the BHHCs, and the BH MCOs of the effectiveness of the interventions implemented between MY 2010 and MY 2012 to promote continuous quality improvement with regard to follow-up care after psychiatric hospitalization. The information contained within this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. The Counties, BHHCs, and BH MCOs participating in this study should continue to evaluate the current interventions in place with respect to their follow-up rates to assess how these interventions affected change in follow-up rates from the prior measurement years MY 2011 and MY 2010. The Counties, BHHCs and BH MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in receiving follow-up care, and then implement action and monitoring plans to further increase their rates.

Recommendation 2: The findings of this re-measurement indicate that disparities in rates between demographic populations continue to persist as seen in prior studies. Within each of the demographic



populations examined (race, age, gender, ethnicity), results were similar to MY 2011. Statistically significantly lower rates were again observed on three or four indicators for: 1) African Americans, 2) members over 21 years old, and 3) males. Statistically significantly lower rates were observed on QIs 1 and 2 for non-Hispanic members. While OMHSAS contracted Counties, BHHCs, and their subcontracted BH MCOs are working to improve their overall follow-up rates, it is also important for these entities to continue to target the demographic populations that do not perform as well as their counterparts. Furthermore, it is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. It is recommended that BH MCOs, BHHCs, and Counties continue to focus interventions on populations that continue to exhibit lower follow-up rates (e.g., Black/African American population). Possible reasons for these rate disparities include access, cultural differences and financial factors, which should all be considered and evaluated to determine their potential impact on performance. Additionally, the BH MCOs should be encouraged to initiate targeted interventions to address disparate rates between study populations.

Recommendation 3: BH MCO and Counties are encouraged to review the findings of the follow-up study in conjunction with inpatient psychiatric readmission rates, as professional literature consistently indicate a high correlation between these measures. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either had or did not have evidence of ambulatory follow-up/aftercare visit(s) during the interim period.

Recommendation 4: Additional analyses of each BH MCO's data should be conducted in order to determine if any other trends are noted. For example, lower follow-up rates may be associated with individuals with particular diagnoses, with co-occurring conditions such as substance abuse and/or addiction, or with particular services. Each BH MCO should evaluate its data for trends, including those indicated within this report. After evaluating the BH MCO data for trends, subject-specific findings should be transmitted to BH MCO, BHHC, and/or County care managers for implementation of appropriate action.

Readmission within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow up After Hospitalization for Mental Illness, OMHSAS elected to 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, then for MY 2008. Re-measurements were conducted in 2010 and 2011 on MY 2009 and MY 2010 data, respectively. The MY 2012 study conducted in 2013 was the sixth re-measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2011. This measure continued to be of interest to OMHSAS for the purposes of comparing County 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. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as 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 subsequently 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 participating in the MY 2012 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, 2012;
- A principal ICD-9-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 must be clearly identified as a discharge.

The numerator was comprised of 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. During the validation process for the MY 2011 study, it was discovered that there were differing interpretations of the specifications with regard to the denominator discharge date. Interpretations differed regarding whether to use December 1 or December 31 when calculating the denominator. IPRO observed a discrepancy in the specifications regarding how to calculate the denominator. IPRO and OMHSAS agreed to examine the specifications for the next review year. For the MY 2012 study, the existing methodology was clarified, and IPRO and OMHSAS worked with the BH-MCOs to ensure a consistent denominator timeframe (January 1 2012 – December 1 2012) was used for this measure.

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. **This measure is an inverted rate, in that lower rates are preferable.**

Findings

BH MCO and County Results

The results are presented at the BH MCO and then County level when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2012 to MY 2011 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-ratio. SSD at the .05 level between groups are noted, as well as the PPD between the rates.

Individual rates are also compared to the categorical average. Rates statistically significantly above and/or below the average are indicated. The average takes the sum of the individual rates and divides the sum by the total number of sub-groups within the category; therefore, all averages presented in this study are *not* weighted. Whether or not an individual rate performed statistically significantly above or below average was determined by whether or not that rate's 95% CI included the average for the indicator.

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



Table 3.4 MY 2011 Readmission Rates with Year-to-Year Comparisons

	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,748	45,346	12.7%	12.4%	13.0%	12.8%	10.8%	12.0%	0.7	NO
CCBH	1,977	16,238	12.2%	11.7%	12.7%			11.1%	1.1	NO
Adams	12	113	10.6%	4.5%	16.7%			7.9%	2.7	NO
Allegheny	595	4,394	13.5%	12.5%	14.6%			12.2%	1.4	NO
Berks	188	1,337	14.1%	12.2%	16.0%			12.7%	1.3	NO
Bradford	28	216	13.0%	8.2%	17.7%			12.1%	0.9	NO
(Cameron)	0	24	0.0%	0.0%	2.1%			0.0%	0.0	NA
Carbon	33	284	11.6%	7.7%	15.5%			8.1%	3.6	NO
Centre	41	302	13.6%	9.6%	17.6%			11.4%	2.2	NO
Chester	85	814	10.4%	8.3%	12.6%			13.9%	-3.4	NO
Clarion	21	165	12.7%	7.3%	18.1%			6.3%	6.4	NO
Clearfield	46	442	10.4%	7.4%	13.4%			9.0%	1.4	NO
Columbia	19	218	8.7%	4.7%	12.7%			8.6%	0.1	NO
Elk	9	125	7.2%	2.3%	12.1%			8.8%	-1.6	NO
Erie	190	1,358	14.0%	12.1%	15.9%			11.8%	2.2	NO
(Forest)	4	24	16.7%	0.0%	33.7%			0.0%	16.7	NO
Huntingdon	13	151	8.6%	3.8%	13.4%			6.7%	1.9	NO
Jefferson	35	293	12.0%	8.1%	15.8%			12.6%	-0.6	NO
(Juniata)	4	51	7.8%	0.0%	16.2%			3.6%	4.3	NO
Lackawanna	105	830	12.7%	10.3%	15.0%			10.6%	2.1	NO
Luzerne	188	1,326	14.2%	12.3%	16.1%			13.0%	1.2	NO
McKean	21	163	12.9%	7.4%	18.3%			11.5%	1.3	NO
Mifflin	33	277	11.9%	7.9%	15.9%			10.9%	1.0	NO
Monroe	30	338	8.9%	5.7%	12.1%			8.8%	0.1	NO
(Montour)	3	59	5.1%	0.0%	11.5%			7.2%	-2.2	NO
Northumberland	23	298	7.7%	4.5%	10.9%			9.1%	-1.4	NO
(Pike)	13	82	15.9%	7.3%	24.4%			6.4%	9.4	NO
(Potter)	3	52	5.8%	0.0%	13.1%			13.3%	-7.6	NO
Schuylkill	74	682	10.9%	8.4%	13.3%			9.3%	1.5	NO
(Snyder)	3	72	4.2%	0.0%	9.5%			3.5%	0.7	NO
(Sullivan)	0	18	0.0%	0.0%	2.8%			0.0%	0.0	NA
(Susquehanna)	3	62	4.8%	0.0%	11.0%			10.3%	-5.5	NO
Tioga	9	118	7.6%	2.4%	12.8%			6.0%	1.6	NO
(Union)	2	81	2.5%	0.0%	6.5%			7.7%	-5.2	NO
Warren	29	210	13.8%	8.9%	18.7%			4.1%	9.7	NO



	MY 2012							MY 2011	RATE COMPARISON MY 2012 to MY 2011	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
Wayne	12	124	9.7%	4.1%	15.3%			4.3%	5.4	NO
(Wyoming)	6	62	9.7%	1.5%	17.8%			8.8%	0.9	NO
York	97	1,073	9.0%	7.3%	10.8%			9.7%	-0.6	NO

Caution should be exercised when interpreting results for small denominators as they produce rates that are less stable. Rates produced for small denominators are subject to greater variability. For small populations, large differences in rates do not necessarily mean there is a statistically significant difference in rates.

The aggregate MY 2012 HealthChoices readmission rate was 12.7%. CCBH's readmission rate was 12.2% in MY 2012, which did not meet the designated goal, but was statistically significantly lower than the MY 2012 HealthChoices BH MCO Average of 12.8%. Note that this measure is an inverted rate, in that lower rates are preferable. CCBH's MY 2012 rate was not statistically significantly different than the BH MCO's MY 2011 rate. Overall, CCBH demonstrated the largest year over year rate increase for readmission among the five BH MCOs evaluated in MY 2012.

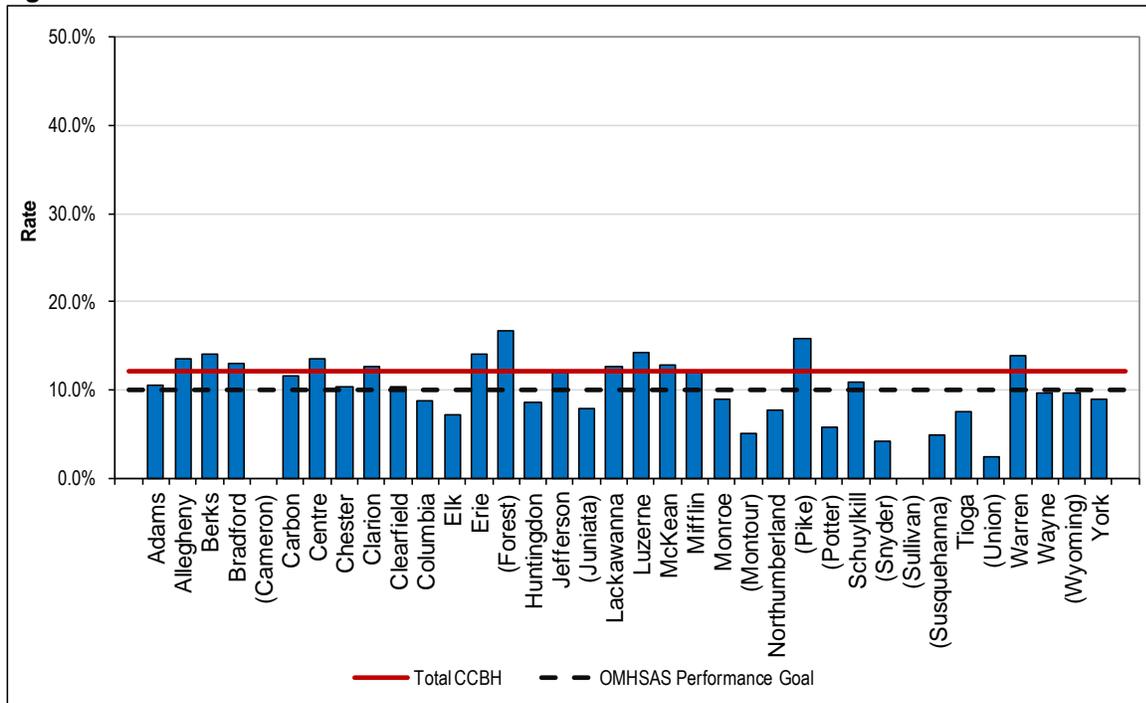
As presented in Table 3.4, 36 Counties were associated with CCBH in MY 2012. Of the Counties with rates for MY 2012, there were no statistically significant differences noted for any Counties when comparing MY 2011 and MY 2012 rates.

For MY 2012, the rates for 17 Counties met the performance goal of 10.0%. These Counties were Cameron, Columbia, Elk, Huntingdon, Juniata, Monroe, Montour, Northumberland, Potter, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, and York. The rates for Cameron, Juniata, Montour, Potter, Snyder, Sullivan, Susquehanna, Union, and Wyoming Counties, however, were determined by less than 100 eligible discharges.

The MY 2012 rates for Allegheny, Berks, Erie and Luzerne Counties were statistically significantly higher (poorer) than the MY 2012 HealthChoices County Average of 10.83%. As noted previously, this rate is inverted, in that lower rates are preferable. The MY 2012 rates for Cameron, Snyder, Sullivan, Union and York Counties were statistically significantly below (better than) the MY 2012 HealthChoices County Average. The rates for Cameron, Snyder, Sullivan and Union Counties were determined by less than 100 eligible discharges.

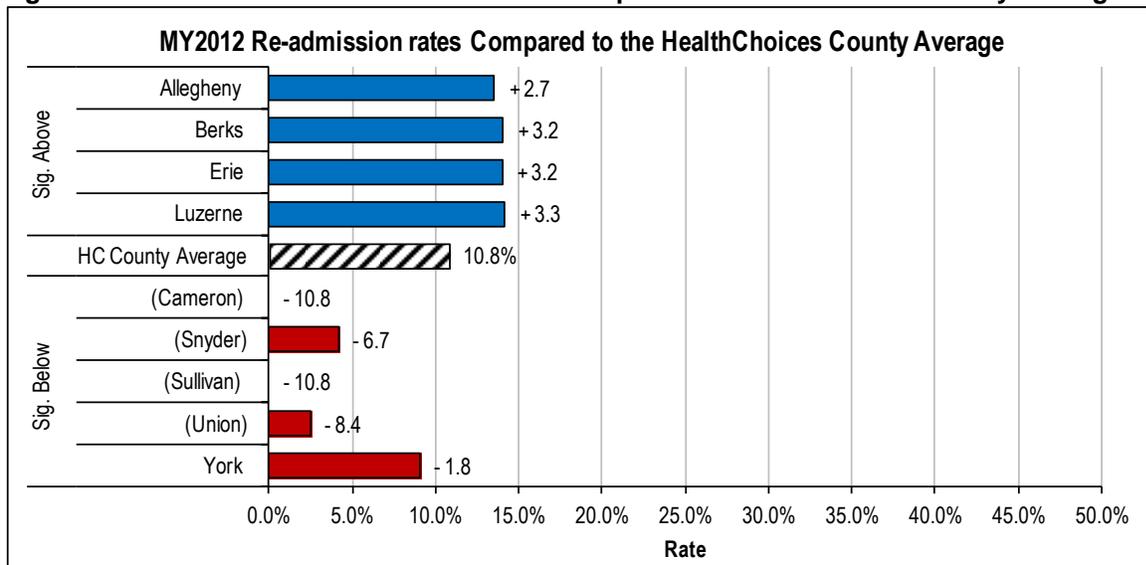
Figure 3.5 provides a graphical presentation of the MY 2011 readmission rates for CCBH and its associated counties. Figure 3.6 displays percentage point differences for the individual CCBH Counties that performed statistically significantly higher or lower than the MY 2011 HealthChoices County Average.

Figure 3.5 MY 2012 Readmission Rates



Note: Counties with rates determined by less than 100 eligible discharges are presented within parentheses.

Figure 3.6 MY 2012 Readmission Rates Compared to HealthChoices County Average



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 that did not meet the performance goal, and/or performed below the HealthChoices BH MCO Average.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the 2013 (MY 2012) Readmission within 30 Days of Inpatient Psychiatric Discharge data tables.



In response to the 2013 study, the following general recommendations are applicable to all five participating BH MCOs:

- As with MY 2011, no significant improvement was noted for any of the BH MCOs for MY 2012. IPRO recommends that the Counties and BH MCOs participating in this study conduct root cause analyses to help determine what factors are negatively impacting readmission rates, and develop interventions that target specific barriers to improving the readmission rates.
- Each BH MCO should conduct additional analyses of the data in order to determine if any other trends are noted. For example, higher readmission rates may be associated with those individuals with particular diagnoses or co-occurring conditions such as substance abuse and/or addiction. Targeted analyses such as these should be evaluated as part of any root cause analysis. In addition, BH MCOs and Counties are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- Unlike MY 2010, but as observed for MY 2011, the MY 2012 readmission rates observed for Black/African American and the White populations were not statistically significantly different. For MY 2012, 52.4% of all African American discharges occurred in Philadelphia County. The statistically significantly lower rates for African Americans in MY 2010 appeared to be driven by the Philadelphia County population, and IPRO recommended that a performance improvement project to focus on Disparities in Healthcare, with a focus on Philadelphia County, be undertaken. Although no formal project began, CBH, which is comprised solely of Philadelphia County, observed the largest improvement among the BH MCOs for MY 2011. This finding may suggest further study across BH MCOs to explore the potential for further improvements that can be sustained.
- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted Counties and their subcontracted BH MCOs.
- Case management consideration should be given to those individuals who appear to be the highest utilizers of inpatient acute psychiatric care and have shown to be at risk for frequent readmission.
- As with MY 2011, considerable variation by county was again observed for all of the BH MCOs for MY 2012. BH MCOs should further evaluate individual County rates, explore the underlying causes of variance by County, and identify those County practices or systems that may contribute to lower readmission rates.

IV: 2012 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 2012 EQR Technical Reports, which were distributed in April 2013. The 2013 EQR Technical Report is the sixth report to include descriptions of current and proposed interventions from each BH MCO that address the 2012 recommendations.

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 September 30, 2013 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 2013, as well as any additional relevant documentation provided by CCBH.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	MCO Response
Structure and Operations Standards		
CCBH 2012.01	Within Subpart C: Enrollee Rights and Protections Regulations, CCBH was partially compliant on one out of seven categories – Enrollee Rights.	<p><u>Follow Up Actions Taken Through 09/30/13</u> EQR Response for Cell 108.10 for York/Adams and Chester Contracts</p>  <p>EQR Response for Cell 108.docx</p>
		<p><u>Future Actions Planned</u> A provider newsletter article focusing on encouraging providers to view C/FST as an independent organization was published in the October 2013 Provider Newsletter.</p>  <p>Article for Provider Newsletter.docx</p>
CCBH 2012.02	CCBH was partially compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant category is: Availability of Services (Access to Care).	<p><u>Follow Up Actions Taken Through 09/30/13</u> <i>From RY 2010 – PEPS 1.2 NorthCentral (SO) - A waiver (provider exception request) was requested and approved by OMHSAS as the following levels of care did not meet the requirement for a choice of 2 providers within 30/60 miles: IP D&A Detox (Child- ALL 23</i></p>

Reference Number	Opportunity for Improvement	MCO Response
		<p>counties); IP D&A Detox (Adult – Centre, Clearfield, Huntington, Juniata, Mifflin, Northumberland, Schuylkill, and Snyder); IP D&A Rehab (Child – ALL 23 Counties; Adult – All Counties except – Clarion, Forest, and Warren); Non-hospital D&A Detox (Child-Bradford, Cameron, Centre, Clarion, Elk, Forest, Jefferson, Juniata, McKean, Potter, Snyder, Tioga, and Warren) Non-hospital D&A Detox (Adult- Bradford, Cameron, Elk, McKean, Potter, and Tioga); Non-hospital D&A Rehab (Child-Cameron, Centre, Clarion, Clearfield, Elk, Forest, Huntington, Jefferson, McKean, Potter, Tioga, and Warren); Non-hospital D&A Rehab (Adult-Bradford); D&A Halfway House (Bradford, Clarion, Forest, McKean, Potter, Tioga, Warren); D&A Methadone (Bradford, Cameron, Centre, Columbia, Elk, Juniata, McKean, Northumberland, Potter, Snyder, Sullivan, Tioga, Union, and Wayne).</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  HCNC Exception Requests_10.20.10.1 </div> <div style="text-align: center;">  DPW_Approval_11.4 .2010.pdf </div> </div> <p>Future Actions Planned Continue to offer members a choice of 2 or more providers within 30/60 miles. When a member cannot access a provider within the standard drive times, Community Care refers a member to the closest provider possible, approves services to nonparticipating providers, or approves a higher level of care. Providers are also added to the network when possible.</p>
CCBH 2012.03	CCBH was partially compliant on four 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) Handling of Grievances and Appeals 4) Resolution and Notification: Grievances and Appeals.	<p>Follow Up Actions Taken Through 09/30/13 All Counties 68.3; 68.5; 68.6; 68.9</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  C_G_Cell_68 revised.doc </div> <div style="text-align: center;">  C_G_Cell_68.5.doc </div> </div> <div style="text-align: center; margin-top: 10px;">  C_G_Cell_68.5_68.9 .docx </div> <p>Future Actions Planned N/A</p>
Performance Measures		
CCBH 2012.04	CCBH's rate for the MY 2011 Q1 1 rate and Q1 2 rate both statistically significantly decreased from MY 2010.	<p>Follow Up Actions Taken Through 09/30/13</p> <div style="text-align: center;">  Follow up interventions_10.25. </div>



Reference Number	Opportunity for Improvement	MCO Response
		<p>Future Actions Planned Community Care will continue to conduct barrier analysis and develop interventions to positively impact this measure.</p>
CCBH 2012.05	CCBH's rate for the MY 2011 QI 1 rate and QI 2 rate both statistically significantly decreased from MY 2010.	<p>Follow Up Actions Taken Through 09/30/13</p> <p> Follow up interventions_10.25.</p> <p>Future Actions Planned Community Care will continue to conduct barrier analysis and develop interventions to positively impact this measure.</p>
CCBH 2012.06	CCBH's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.	<p>Follow Up Actions Taken Through 09/30/13</p> <p> Readmission Interventions through</p> <p>Future Actions Planned Community Care will continue to conduct barrier analysis and develop interventions to positively impact this measure.</p>

Corrective Action Plan

When deficiencies were noted during the PEPS reviews, a Corrective Action Plan response was required from the BH MCO addressing those issues requiring follow-up action. CCBH was not required to implement any corrective action plans in calendar year 2012.

Root Cause Analysis and Action Plan

The 2013 EQR is the fourth for which BH MCOs were required to prepare a Root Cause Analysis and Action Plan for performance measures performing statistically significantly poorer than the BH MCO average and/or as compared to the prior measurement year. The performance measures that were noted as opportunities for improvement in the 2012 EQR Technical Report required that the MCO 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.

IPRO reviewed each submission, and offered technical assistance to BH MCO staff. The BH MCOs were given the opportunity to revise and re-submit response forms as needed and as time permitted. CCBH was not required to submit a root cause analysis and action plan in 2013 based on 2012 Performance.



V: 2013 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of CCBH's 2013 (MY 2012) performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of and access to services for Medicaid members served by this BH MCO.

Strengths

- CCBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness HEDIS indicator QI 1 was statistically significantly higher than the MY 2012 HealthChoices BH MCO Average by 3.0 percentage points. Overall, CCBH's rates were the highest for QI 1 and QI 2 among the five BH MCOs evaluated in MY 2012.
- CCBH's rate for the MY 2012 Follow-up After Hospitalization for Mental Illness PA-specific indicator QI A was statistically significantly higher than the MY 2012 HealthChoices BH MCO Average by 2.9 percentage points. Overall, CCBH's rates were the highest for QI A and QI B among the five BH MCOs evaluated in MY 2012.
- CCBH's rate for the MY 2012 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure was statistically significantly lower (better) than the MY 2012 HealthChoices BH MCO Average by 0.6 percentage points.
- CCBH submitted one PIP for validation in 2013 and received full credit for the element of the study evaluated that reflects activities in 2012 (Sustained Improvement).

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2010, RY 2011, and RY 2012 found CCBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
 - Within Subpart C: Enrollee Rights and Protections Regulations, CCBH was partially compliant on one out of seven categories – Enrollee Rights.
 - CCBH was partially compliant on three and non-compliant on one out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, and 3) Practice Guidelines. The non-compliant category was Coordination and Continuity of Care.
 - CCBH was partially compliant on nine 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) Information to Providers & Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions
- CCBH demonstrated the largest year over year rate increase for readmission among the five BH MCOs evaluated in MY 2012.
- CCBH's rate for the MY 2011 Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.

Additional strengths and targeted opportunities for improvement can be found in the BH MCO-specific 2013 (MY 2012) Performance Measure Matrices that follow.



PERFORMANCE MEASURE MATRICES

The Performance Measure (PM) Matrices provide a comparative look at quality indicators (QIs) included in the External Quality Review (EQR) evaluation for Quality Performance of the HealthChoices BH MCO.

The first matrix and table (Figures 1.1 – 1.2):

- Compares the BH MCO's own measure performance over the two most recent reporting years (Measurement Year (MY) 2012 and MY 2011); and
- Compares the BH MCO's MY 2012 performance measure rates to the MY 2012 HealthChoices BH MCO Average.

Figure 1.1 is a three-by-three matrix. The horizontal comparison represents the BH MCO's performance as compared to the applicable HealthChoices BH MCO Average. When comparing a BH MCO's rate to the HealthChoices BH MCO Average for each indicator, the BH MCO rate can be above average, equal to the average or below average. Whether or not a BH MCO performed statistically significantly above or below average is determined by whether or not that BH MCO's 95% confidence interval for the rate included the HealthChoices BH MCO Average for the specific indicator.

Figure 1.2 represents the BH MCO's performance for each measure in relation to its prior year's rates for the same indicator. The BH MCO's rate can trend up (▲), have no change, or trend down (▼). For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

The second matrix and table (Figures 2.1 – 2.2):

- Compares the BH MCO's MY 2012 performance to the HEDIS 90th, 75th, 50th and 25th percentiles for applicable measures (FUH QIs 1 and 2, the HEDIS 7- and 30-day indicators).

Figure 2.1 is a four-by-one matrix. This represents the BH MCO's performance as compared to the HEDIS 90th, 75th, 50th and 25th percentiles for the Follow-Up After Hospitalization 7-day/30-day metrics (FUH7/FUH30). A root cause analysis and plan of action is required for items that fall below the 75th percentile.

Figure 2.2 illustrates the rates achieved compared to the HEDIS 75th percentile goal. Results are not compared to the prior year's rates.

The matrices are color-coded to indicate when the findings for these measures are notable and whether there is cause for action:

-  The green box (A) indicates either that the BH MCO's MY 2012 rate is statistically significantly above the MY 2012 HealthChoices BH MCO Average and trends up from MY 2011.
-  The light green boxes (B) indicate either that the BH MCO's MY 2012 rate is equal to the MY 2012 HealthChoices BH MCO Average and trends up from MY 2011 or that the BH MCO's MY 2012 rate is statistically significantly above the MY 2012 HealthChoices BH MCO Average but there is no change from MY 2011.
-  The yellow boxes (C) indicate that the BH MCO's MY 2012 rate is statistically significantly below the MY 2012 HealthChoices BH MCO Average and trends up from MY 2011 or that the BH MCO's MY 2012 rate is equal to the MY 2012 HealthChoices BH MCO Average and there is no change from MY 2011 or that the BH MCO's MY 2012 rate is statistically significantly above the MY 2012 HealthChoices BH MCO Average but trends down from MY 2011. *No action is required although MCOs should identify continued opportunities for improvement.*
-  The orange boxes (D) indicate either that the BH MCO's MY 2012 rate is statistically significantly below the MY 2012 HealthChoices BH MCO Average and there is no change from MY 2011 or that the BH MCO's MY 2012 rate is equal to the MY 2012 HealthChoices BH MCO Average and trends down from MY 2011. *A root cause analysis and plan of action is required.*
-  The red boxes (F) indicate that the BH MCO's MY 2012 rate is statistically significantly below the MY 2012 HealthChoices BH MCO Average and trends down from MY 2011. *A root cause analysis and plan of action is required in both cases.*



Community Care Behavioral Health (CCBH)

KEY POINTS

▪ A - Performance is notable. No action required. BH MCOs may have internal goals to improve.

- No CCBH performance measure rate fell into this comparison category.

▪ B - No action required. BH MCO may identify continued opportunities for improvement.

- Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)
- Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)
- Readmission within 30 Days of Inpatient Psychiatric Discharge¹

▪ C - No action required although BH MCO should identify continued opportunities for improvement.

- No CCBH performance measure rate fell into this comparison category.

▪ D - Root cause analysis and plan of action required.

- Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
- Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)

• F - Root cause analysis and plan of action required.

- No CCBH performance measure rate fell into this comparison category.

¹ Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Community Care Behavioral Health (CCBH)

Figure 1.1: Performance Measure Matrix – CCBH

		HealthChoices BH MCO Average Statistical Significance Comparison		
Year to Year Statistical Significance Comparison	Trend	Below / Poorer than Average	Average	Above / Better than Average
	▲	C	B	A
	No Change	D	C	B FUH QI A FUH QI B REA ¹
▼	F	D	C	

Key to the Performance Measure Matrix Comparison

- A: Performance is notable. No action required. BH MCOs may have internal goals to improve.
- B: No action required. BH MCOs may identify continued opportunities for improvement.
- C: No action required although BH MCOs should identify continued opportunities for improvement.
- D: Root cause analysis and plan of action required.
- F: Root cause analysis and plan of action required.

Performance measure rates for MY 2010, MY 2011, and MY 2012 are displayed in Figure 1.2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

- ▲ Statistically significantly higher than the prior year,
- ▼ Statistically significantly lower than the prior year, or
- = No change from the prior year.

Figure 1.2: Performance Measure Rates – CCBH

Quality Performance Measure	MY 2010 Rate	MY 2011 Rate	MY 2012 Rate	MY 2012 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	62.5% =	60.3% ▼	61.1% =	58.2%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	78.9% =	77.6% ▼	77.7% =	74.8%
Readmission within 30 Days of Inpatient Psychiatric Discharge ¹	10.8% =	11.1% =	12.2% =	12.8%

¹ Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Community Care Behavioral Health (CCBH)

Figure 2.1: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Matrix – CCBH

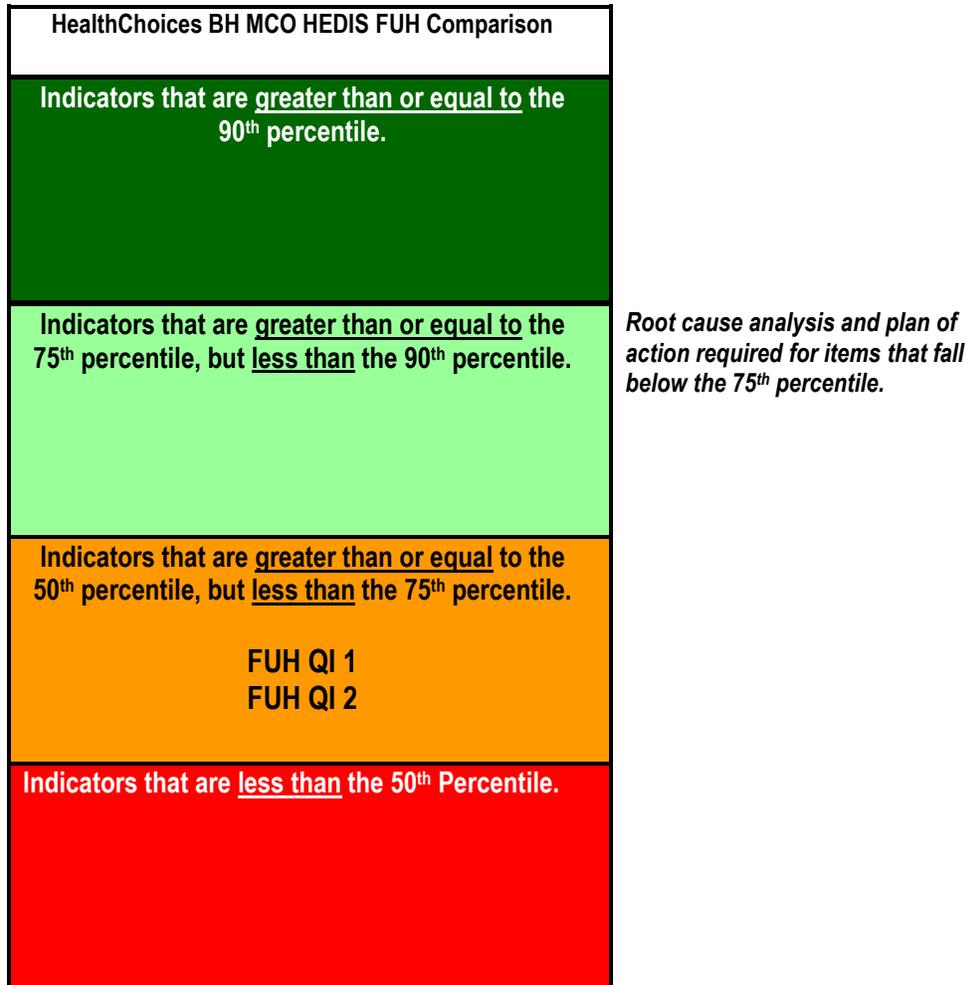


Figure 2.2: HEDIS Follow-Up After Hospitalization (FUH) 7-day/30-day Performance Measure Rates – CCBH

Quality Performance Measure	MY 2012 Rate	HEDIS 2013 75 th ile
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	49.7% Not Met	54.8%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	71.7% Not Met	75.7%

¹ Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



VI: SUMMARY OF ACTIVITIES

Structure and Operations Standards

- CCBH was partially compliant on Subparts C, D, and F of the Structure and Operations Standards. As applicable, compliance review findings from RY 2012, RY 2011, and RY 2010 were used to make the determinations.

Performance Improvement Projects

- CCBH submitted one PIP for validation in 2013 and received full credit for the element of the study evaluated that reflects activities in 2012 (Sustained Improvement).

Performance Measures

- CCBH reported all performance measures and applicable quality indicators in 2013.

2012 Opportunities for Improvement MCO Response

- CCBH provided a response to the opportunities for improvement issued in 2012.

2013 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CCBH in 2013. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2014.



APPENDIX

Appendix A: Crosswalk of Required PEPS Substandards to Pertinent BBA Regulations

BBA Category	PEPS Reference	PEPS Language
§438.100 Enrollee rights	Standard 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.
	Standard 60.2	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.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 108.1	County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.
	Standard 108.2	C/FST budget is sufficient to: hire staff proportionate to HC covered lives, has adequate office space, purchase equipment, travel and attend on-going training.
	Standard 108.5	The C/FST has access to providers and HC members to conduct surveys and employs of a variety of survey mechanisms to determine member satisfaction e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc.
	Standard 108.6	The problem resolution process specifies the role of the County, BH-MCO and C/FST and providers and results in timely follow-up of issues identified in quarterly surveys.
	Standard 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.
	Standard 108.8	The Annual Mailed/Telephonic survey results are representative of HC membership, identify systemic trends and actions have been taken to address areas found deficient, as applicable.
Standard 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	Standard 1.1	<ul style="list-style-type: none"> • A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (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 data base 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.
	Standard 1.2	100% of members given choice of 2 providers at each level of care within 30/60 urban/rural met.



BBA Category	PEPS Reference	PEPS Language
	Standard 1.3	Provider Exception report submitted & approved when choice of two providers is not given.
	Standard 1.4	BH-MCO has identified & addressed any gaps in provider network (e.g. cultural, special priority, needs pops or specific services).
	Standard 1.5	BH-MCO has notified DPW of any drop in provider network. <ul style="list-style-type: none"> • Monitor provider turnover. • Network remains open where needed.
	Standard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not excepting any new enrollees.
	Standard 1.7	Confirm FQHC providers.
	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if 5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 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.
	Standard 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.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.208 Coordination and Continuity of Care	Standard 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.
	Standard 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	Standard 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.
	Standard 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.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.2104	Standard 10.1	100% of credentialed files should contain licensing or certification required by PA law,



BBA Category	PEPS Reference	PEPS Language
Provider Selection		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.
	Standard 10.2	100% of decisions made within 180 days of receipt of application.
	Standard 10.3	Recredentialing incorporates results of provider profiling.
§438.230 Subcontractual relationships and delegation	Standard 99.1	The BH-MCO reports monitoring results for Quality of individualized service plans and treatment planning.
	Standard 99.2	The BH-MCO reports monitoring results for Adverse Incidents.
	Standard 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.
	Standard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Standard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Standard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Standard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Standard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
§438.236 Practice guidelines	Standard 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.
	Standard 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.
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
§438.240 Quality assessment and performance improvement program	Standard 91.1	QM program description outlines the ongoing quality assessment and performance improvement activities, Continuous Quality Improvement process and places emphasis on, but not limited to High volume/high-risk services and treatment and Behavioral Health Rehabilitation services.
	Standard 91.2	QM work plan includes goal, aspect of care/ service, scope of activity, frequency, data source, sample size, responsible person and performance goal, as applicable.
	Standard 91.3	QM work plan outlines: The specific activities related to coordination and interaction with PH-MCO.
	Standard 91.4	QM work plan outlines, the joint studies to be conducted.
	Standard 91.5	The QM work plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members (access to services, provider network adequacy, penetration rates, appropriateness of service authorizations, inter-rater reliability, complaint, grievance and appeal process, denial rates, grievance upheld and overturn rates and treatment outcomes).
	Standard 91.6	The QM work plan includes a Provider Profiling process.
	Standard 91.7	The QM work plan includes the specific monitoring activities conducted to evaluate the quality and effectiveness of internal processes (telephone access and responsiveness rates, overall utilization patterns and trends including BHRS and other HV/HR services).

BBA Category	PEPS Reference	PEPS Language
	Standard 91.8	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).
	Standard 91.9	The QM work plan includes a process for determining provider satisfaction with the BH-MCO.
	Standard 91.10	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 for : ---Mental Health ---Substance Abuse External Quality Review: ---Follow up After Mental Health Hospitalization QM Annual Summary Report
	Standard 91.11	The identified Performance Improvement Projects must include the following: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality. 3. Evaluation of the effectiveness of the interventions. 4. Planning and initiation of activities for increasing or sustaining improvement. 5. Timeline for reporting status and results of each project to DPW. 6. 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.
	Standard 91.12	The QM work plan outlines other performance improvement activities to be conducted based on the findings of the Annual Summary Report and any Corrective Actions required from previous reviews.
	Standard 91.13	The BH-MCO has a process for its own evaluation of the impact and effectiveness of its quality management program annually. A report of this evaluation will be submitted to DPW by April 15 th .
	Standard 93.1	The BH-MCO reports monitoring results for Access to Services (routine, urgent & emergent), Provider network adequacy and Penetration rates.
	Standard 93.2	The BH-MCO reports monitoring results for Appropriateness of service authorization and Inter-rater Reliability.
	Standard 93.3	The BH-MCO reports monitoring results for Authorization and complaint, grievance and appeal process, denial rates and grievance upheld and overturn rates.
	Standard 93.4	The BH-MCO reports monitoring results for Treatment Outcomes: Readmission Rates, Follow up after hospitalization rates, Consumer satisfaction, Changes in employment/educational /vocational status and Changes in living status.
	Standard 98.1	The BH-MCO reports monitoring results for Telephone access standard and responsiveness rates. Standard: Abandonment rate <5%, average speed of answer < 30 seconds
	Standard 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.
	Standard 98.3	The BH-MCO reports monitoring results for Coordination with Other Service Agencies and School.
	Standard 104.1	The BH-MCOs must measure and report its performance using standard measures required by DPW.
	Standard 104.2	The BH-MCO must submit to the DPW data specified by the DPW, that enables the measurement of the BH-MCO's performance QM program description must outline



BBA Category	PEPS Reference	PEPS Language
		timeline for submission of QM program description, work plan, annual QM Summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DPW.
	Standard 104.3	Performance Improvement Plans status reported within the established time frames.
§438.242 Health information systems	Standard 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	Standard 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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	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.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	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.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

BBA Category	PEPS Reference	PEPS Language
§438.402 General requirements	Standard 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.
	Standard 60.2	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.
	Standard 60.3	Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.
	Standard 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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	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.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	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.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.	
§438.404 Notice of action	Standard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Standard 23.2	BH-MCO phone answering procedures provides instruction for non-English members if



BBA Category	PEPS Reference	PEPS Language
		5% requirement is met.
	Standard 23.3	List of interpreters is available for non-English Speakers.
	Standard 24.1	BH-MCO provides application includes information about handicapped accessibility.
	Standard 24.2	Provider network data base contains required information for ADA compliance.
	Standard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Standard 24.4	BH-MCO is able to access to interpreter services.
	Standard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Standard 24.6	BH-MCO can make alternate formats available upon request.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.406 Handling of grievances and appeals	Standard 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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	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.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	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.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.



BBA Category	PEPS Reference	PEPS Language
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.408 Resolution and notification: Grievances and appeals	Standard 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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 68.2	100% of Complaint Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 68.3	Complaint decisions letters are 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).
	Standard 68.4	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.
	Standard 68.5	Complaint case files include documentation of any referral of complaint issues, especially valid complaint issues to County/BH-MCO Committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the complaint case file or reference in the case file to where the documentation can be obtained for review.
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	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.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.



BBA Category	PEPS Reference	PEPS Language
§438.410 Expedited resolution of appeals	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	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.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.414 Information about the grievance system to providers and subcontractors	Standard 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. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External
	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	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.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G 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.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
§438.424 Effectuation of reversed appeal resolutions	Standard 71.1	Procedures are made known to members, BH-MCO staff and the provider network. <ul style="list-style-type: none"> • BBA Fair Hearing • 1st Level • 2nd Level • External • Expedited
	Standard 71.2	100% of Grievance Acknowledgement and Decision Letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Standard 71.3	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.
	Standard 71.4	Grievance case files must include documentation of any referrals to County/BH-MCO committees for further review and follow up. Evidence of subsequent corrective action and follow-up by the respective County/BH-MCO Committee must be available to the C/G staff either by inclusion in the grievance case file or reference in the case file to where the documentation can be obtained for review.
	Standard 72.1	Denial notices are issued to members in a timely manner using the required template. The content of the notices adhere to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.
	Standard 72.2	Denial case files include complete and appropriate documentation according to OMHSAS requirements. A comprehensive review of findings is in the OMHSAS Quality Management Denial Summary Report for the respective review year.

Appendix B: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Second Level Complaints and Grievances		
Complaints	Standard 68.6	The second level complaint case file includes documentation that the member was contacted about the 2nd level complaint meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 68.7	Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.
	Standard 68.8	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 68.9	Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.
Grievances and State Fair Hearings	Standard 71.5	The second level grievance case file includes documentation that the member was contacted about the 2nd level grievance meeting and offered a convenient time and place for the meeting and asked about their ability to get to the meeting and if they need any assistive devices.
	Standard 71.6	Training rosters identify that all 2nd level panel members have been trained. Include a



Category	PEPS Reference	PEPS Language
		copy of the training curriculum.
	Standard 71.7	A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Standard 71.8	Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.
Enrollee Satisfaction		
Consumer / Family Satisfaction	Standard 108.3	County/BH MCO role of fiduciary (if applicable) is clearly defined, provides supportive function as defined in C/FST Contract as opposed to directing the program.
	Standard 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.
	Standard 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 CCBH Counties

OMHSAS-specific items are not required to fulfill BBA requirements. In RY 2012, 11 substandards were considered OMHSAS-specific monitoring standards, and were reviewed. Tables C.1a and C.1b provide a count of these items, along with the relevant categories. Each of the CCBH Counties was evaluated on all 11 OMHSAS-specific substandards.

Table C.1a OMHSAS-Specific Substandards Reviewed for Adams, Allegheny, Berks, Chester, York, NBHCC, and NC/CO Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0

Table C.1b OMHSAS-Specific Substandards Reviewed for NC/SO Counties

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2012	PEPS Reviewed in RY 2011	PEPS Reviewed in RY 2010	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	4	0	0	0
Grievances and State Fair Hearings (Standard 71)	4	4	0	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0

Format

This document groups the monitoring standards under the subject headings Second Level Complaints and Grievances, and Enrollee Satisfaction. The status of each Substandard is presented as it appears in the PEPS tools (i.e., met, partially met, or not met) and/or applicable RAI tools (i.e., complete or pending)



submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the County/BH MCO's compliance on selected ongoing OMHSAS-specific monitoring standards.

Findings

The OMHSAS-specific PEPS Substandards relating to second level complaints and grievances are MCO and County-specific review standards. Beginning with RY 2012, MCO-specific substandards 68.9 and 71.8 were changed to County-specific substandards and renumbered to 68.1 and 78.1 respectively under the County-specific standard set. Eight substandards were evaluated for all counties during RY 2012. Adams, Allegheny, Berks, NBHCC, NC/CO, NC/SO and York Counties met three substandards, partially met four substandards, and did not meet one substandard. Chester County met four substandards, partially met three substandards, and did not meet one substandard. Findings are presented Table C.2.

Table C.2 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances for CCBH Counties

Category	PEPS Item	Review Year	Status by County	Partially Met	Not Met
			Met		
Second Level Complaints and Grievances					
Complaints	Standard 68.6	RY 2012	All Counties		
	Standard 68.7	RY 2012	All Counties		
	Standard 68.8	RY 2012		All Counties	
	Standard 68.1*	RY 2012		All Counties	
Grievances and State Fair Hearings	Standard 71.5	RY 2012	All Counties		
	Standard 71.6	RY 2012		All Counties	
	Standard 71.7	RY 2012			All Counties
	Standard 71.1*	RY 2012	Chester	Adams, Allegheny, Berks, NBHCC, NC/CO, NC/SO and York	

* County-specific substandards 68.1 and 78.1, formerly MCO-specific substandards 68.9 and 71.8.

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.

CCBH was “partially met” on Substandard 68.8 (RY 2012):

Substandard 68.8: A transcript and/or tape recording of the 2nd level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

All CCBH Counties were “partially met” on County-specific Substandard 68.1 (*formerly MCO-specific Substandard 68.9*) (RY 2012):

Substandard 68.1: Where applicable there is evidence of County oversight and involvement in the 2nd level complaint process.

PEPS Standard 71: 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.

CCBH was “partially met” on Substandard 71.6 (RY 2012):

Substandard 71.6: Training rosters identify that all 2nd level panel members have been trained. Include a copy of the training curriculum.



CCBH was “not met” on Substandard 71.7 (RY 2012):

Substandard 71.7: A transcript and/or tape recording of the second level committee meeting will be maintained to demonstrate appropriate representation, familiarity with the issues being discussed and that the decision was based on input from all panel members.

Adams, Allegheny, Berks, NBHCC, NC/CO, NC/SO and York Counties were “partially met” on County-specific Substandard 71.1 (formerly MCO-specific Substandard 71.8) (RY 2012):

Substandard 71.1: Where applicable there is evidence of County oversight and involvement in the 2nd level grievance process.

The OMHSAS-specific Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the 35 CCBH Counties and were compliant on all three substandards. Statuses by County are presented in Tables C.3a and C.3b.

Table C.3a OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for Adams, Allegheny, Berks, Chester, NBHCC, NC/CO and York Counties

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2011	Met
	Standard 108.4	RY 2011	Met
	Standard 108.9	RY 2011	Met

Table C.3b OMHSAS-Specific Requirements Relating to Enrollee Satisfaction for NC/SO Counties

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2010	Met
	Standard 108.4	RY 2010	Met
	Standard 108.9	RY 2010	Met

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