



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

2010 External Quality Review Report
Community 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 intervals (CIs) are ranges 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 the behavioral health (BH) managed care organization (MCO) numerators divided by the sum of the 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.
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	In statistics, a result is described as statistically significant if it 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	The z-ratio expresses 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 Commonwealth of Pennsylvania (PA) Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2010 EQRs for the HealthChoices Medicaid 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: 2009 Opportunities for Improvement MCO Response
- V: 2010 Strengths and Opportunities for Improvement
- VI: Summary of Activities

For the Behavioral Health (BH) Medicaid MCOs, the information for the compliance with 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 the second and third sections 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.

The fourth section includes the BH MCO's responses to opportunities for improvement noted in the 2009 EQR Technical Report and presents the degree to which the BH MCO addressed each opportunity for improvement. The fifth section has a summary of the BH MCO's strengths and opportunities for improvement for this review period as determined by IPRO, and a "report card" of the BH MCO's performance as related to the Pay for Performance (P4P) measures.

The sixth section is a summary of activities for the BH MCO, followed by an appendix of the crosswalk of PEPS Items to Pertinent BBA Regulations and OMHSAS-specific PEPS Items, and a list of literature references cited in the report.



I: STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of Community Behavioral Health's (CBH's) compliance with structure and operations standards. In Review Year (RY) 2009, all 67 PA Counties participated in this compliance evaluation. 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. The Counties provide monitoring and oversight of the BH MCOs. The remaining County contracts are managed directly by OMHSAS since the Counties elected not to bid on the HealthChoices contract directly. Each County subsequently chose a BH MCO subcontractor, which operates under the authority of that County, to administer behavioral health and substance abuse services. Philadelphia County holds a contract with CBH. 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. IPRO's EQR is based on OMHSAS reviews of Philadelphia County and CBH.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CBH by OMHSAS monitoring staff within the past three years. These evaluations are performed at the BH MCO and County levels, and the findings are reported in OMHSAS' PEPS review tools for RY 2009. 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 Items are considered Readiness Review Items only. Items reviewed at the time of the Readiness Review upon initiation of the HealthChoices 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 Items were deemed as complete. As necessary, the HealthChoices Behavioral Health 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 as of October 2010 for RY 2009. 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 Items that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Items 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 multiple review Items, all of the Items 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 review Items 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 Items no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Items 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 Items concerning second level complaints and grievances are considered OMHSAS-specific Items, and their compliance



statuses are not used to make the compliance determination of the applicable BBA category. As was done for the 2009 technical report, review findings pertaining to the required BBA regulations are presented in the first section of this chapter. The review findings for selected OMHSAS-specific Items are reported in the second section of this chapter. The RY 2009 crosswalk of PEPS Items to pertinent BBA regulations and a list of the OMHSAS-specific PEPS Items can be found in the Appendix.

Because OMHSAS reviews the Counties and their subcontracted BH MCOs on 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 Items from RY 2009, RY 2008, and RY 2007 provided the information necessary for the 2010 assessment. Those standards not reviewed through the PEPS system in RY 2009 were evaluated on their performance based on RY 2008 and/or RY 2007 decisions, or other supporting documentation, if necessary. For those Counties that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Items were evaluated when none of the PEPS Items crosswalked to a particular BBA category were reviewed.

For CBH, this year a total of 137 Items were identified as being required for the evaluation of County/BH MCO compliance with the BBA regulations across the PEPS tools. 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 Items were relevant to more than one provision, and that one or more provisions apply to each of the categories. Table 1.1 provides a count of Items pertinent to BBA regulations from the relevant review years used to evaluate the performance of CBH against the Structure and Operations Standards for this report. Table 1.5 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 Items Pertinent to BBA Regulations for CBH and Philadelphia County

Table 1.1 Items Pertinent to BBA Regulations Reviewed for CBH

BBA Regulation	Total # of Items	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	PEPS Reviewed in RY 2007	Not Reviewed
Subpart C: Enrollee Rights and Protections					
Enrollee Rights	12	2	7	3	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	4	17	0	1
Coordination and Continuity of Care	2	0	2	0	0
Coverage and Authorization of Services	4	2	2	0	0
Provider Selection	3	0	2	0	0
Confidentiality	0	0	0	0	0
Subcontractual Relationships and Delegations	8	8	0	0	0
Practice Guidelines	6	4	2	0	0
Quality Assessment and Performance Improvement Program	23	23	0	0	0
Health Information Systems	1	1	0	0	0
Subpart F: Federal & State Grievance Systems Standards					
Statutory Basis and Definitions	7	2	0	5	0
General Requirements	10	2	0	8	0
Notice of Action	11	2	9	0	0
Handling of Grievances and Appeals	7	2	0	5	0
Resolution and Notification: Grievances and Appeals	7	2	0	5	0
Expedited Appeals Process	4	2	0	2	0
Information to Providers and Subcontractors	2	0	0	2	0
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	4	2	0	2	0
Effectuation of Reversed Resolutions	4	2	0	2	0

For RY 2009, 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 Items reviewed. As per OMHSAS' judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health 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. 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 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 Items by provision and evaluated the Counties and BH MCO's compliance status with regard to the PEPS Items. Each Item was assigned a value of met, partially met or not met in the PEPS tools submitted by the Commonwealth. If an Item 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 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 'N/A' was assigned for that provision. A value of Null was assigned to a provision when none of the existing PEPS Items 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

Of the 137 PEPS Items identified as required to fulfill BBA regulations, 136 Items were evaluated for CBH/Philadelphia County.



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 and 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	Compliance	Comments
Enrollee Rights 438.100	Compliant	12 Items were crosswalked to this category. Philadelphia County was evaluated on 12 Items and compliant on 12 Items.
Provider-Enrollee Communications 438.102	Compliant	Compliant as per PS&R sections E.4 (p.50) and A.3.a (p.24).
Marketing Activities 438.104	N/A	Not Applicable due to CMS HealthChoices waiver. Consumers are assigned to BH MCOs based on their County of residence.
Liability for Payment 438.106	Compliant	Compliant as per PS&R sections A.9 (p.63) and C.2 (p.34).
Cost Sharing 438.108	Compliant	Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50-447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	Compliant as per PS&R section 3.d (p.31).
Solvency Standards 438.116	Compliant	Compliant as per PS&R sections A.3 (p.60) and A.9 (p.63), and 2009-2010 Solvency Requirements tracking report.

There are seven categories within Enrollee Rights and Protections Standards. CBH was compliant on six categories. The remaining category was considered Not Applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the six 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 remaining category, Solvency Standards, was compliant based on the 2009-2010 Solvency Requirement tracking report. Philadelphia County was evaluated and compliant on all 12 PEPS Items that were crosswalked to Enrollee Rights and Protections Regulations, and was deemed compliant for the category Enrollee Rights.

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 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	Compliance	Comments
Elements of State Quality Strategies 438.204	Compliant	Compliant as per PS&R section G.3 (p.55).
Availability of Services (Access to Care) 438.206	Partial	22 Items were crosswalked to this category. Philadelphia County was evaluated on 21 Items, compliant on 20 Items, and partially compliant on 1 Item.
Coordination and Continuity of Care 438.208	Partial	2 Items were crosswalked to this category. Philadelphia County was evaluated on 2 Items, compliant on 1 Item, and partially compliant on 1 Item.
Coverage and Authorization of Services 438.210	Partial	4 Items were crosswalked to this category. Philadelphia County was evaluated on 4 Items, compliant on 2 Items, and partially compliant on 2 Items.
Provider Selection 438.214	Partial	3 Items were crosswalked to this category. Philadelphia County was evaluated on 3 Items, compliant on 1 Item, and partially compliant on 2 Items.
Confidentiality 438.224	Compliant	Compliant as per PS&R sections D.2 (p.47), G.4 (p.55-56) and C.7.c (p.46).
Subcontractual Relationships and Delegation 438.230	Compliant	8 Items were crosswalked to this category. Philadelphia County was evaluated on 8 Items and compliant on 8 Items.
Practice Guidelines 438.236	Partial	6 Items were crosswalked to this category. Philadelphia County was evaluated on 6 Items, compliant on 5 Items, and partially compliant on 1 Item.
Quality Assessment and Performance Improvement Program 438.240	Compliant	23 Items were crosswalked to this category. Philadelphia County was evaluated on 23 Items and compliant on 23 Items.
Health Information Systems 438.242	Compliant	1 Item was crosswalked to this category. Philadelphia County was evaluated on 1 Item and compliant on this Item.

Based on the Items reviewed for the 10 categories of Quality Assessment and Performance Improvement Regulations, Philadelphia County was fully compliant on five categories and partially compliant on five categories. Philadelphia County was compliant on the categories Elements of State Quality Strategies and Confidentiality per the HealthChoices PS&R, as these categories were not directly addressed by any PEPS Items.

Of the 69 PEPS Items crosswalked to Quality Assessment and Performance Improvement, 68 were evaluated for Philadelphia County. Sixty-one out of the 68 Items evaluated were partially compliant for Philadelphia County. Those Items deemed partially compliant may correlate to a fewer number of PEPS substandards deemed partially compliant. As stated previously, some PEPS standards are crosswalked to more than one category.



Availability of Services (Access to Care)

Philadelphia County was partially compliant with Availability of Services (Access to Care) due to partial compliance with a substandard of PEPS Standard 28.

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

The partial compliance determination for Philadelphia County was:

Philadelphia County was partially compliant on one substandard of Standard 28: #2 (RY 2008).

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.

Coordination and Continuity of Care

Philadelphia County was partially compliant with Coordination and Continuity of Care due to partial compliance with a substandard of PEPS Standard 28.

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

Coverage and Authorization of Services

Philadelphia County was partially compliant with Coverage and Authorization of Services due to partial compliance with substandards of PEPS Standards 28 and 72.

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

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.

The partial compliance determination for Philadelphia County was:

Philadelphia County was partially compliant on one substandard of Standard 72: #1 (RY 2009).

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.



Provider Selection

Philadelphia County was partially compliant with Provider Selection due to partial compliance with two substandards of PEPS Standard 10.

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

The partial compliance determinations for Philadelphia County were:

Philadelphia County was partially compliant on two substandards of Standard 10: #1 and #3 (RY 2008).

Substandard 1: 100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the Medical Assistance (MA) and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH MCO on-site review, as applicable.

Substandard 3: Recredentialing incorporates results of provider profiling.

Practice Guidelines

Philadelphia County was partially compliant with Practice Guidelines due to partial compliance with a substandard of PEPS Standard 28.

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

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 for each County 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	Compliance	Comments
Statutory Basis and Definitions 438.400	Partial	7 Items were crosswalked to this category. Philadelphia County was evaluated on 7 Items, compliant on 4 Items, and partially compliant on 3 Items.
General Requirements 438.402	Partial	10 Items were crosswalked to this category. Philadelphia County was evaluated on 10 Items, compliant on 7 Items, and partially compliant on 3 Items.
Notice of Action 438.404	Partial	11 Items were crosswalked to this category. Philadelphia County was evaluated on 11 Items, compliant on 10 Items, and partially compliant on 1 Item.



Federal and State Grievance System Standards		
Subpart F: Categories	Compliance	Comments
Handling of Grievances and Appeals 438.406	Partial	7 Items were crosswalked to this category. Philadelphia County was evaluated on 7 Items, compliant on 4 Items, and partially compliant on 3 Items.
Resolution and Notification: Grievances and Appeals 438.408	Partial	7 Items were crosswalked to this category. Philadelphia County was evaluated on 7 Items, compliant on 4 Items, and partially compliant on 3 Items.
Expedited Appeals Process 438.410	Partial	4 Items were crosswalked to this category. Philadelphia County was evaluated on 4 Items, compliant on 1 Item, and partially compliant on 3 Items.
Information to Providers & Subcontractors 438.414	Partial	2 Items were crosswalked to this category. Philadelphia County was evaluated on 2 Items, compliant on 1 Item, and partially compliant on 1 Item.
Recordkeeping and Recording Requirements 438.416	Compliant	Compliant as per 2009 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports.
Continuation of Benefits 438.420	Partial	4 Items were crosswalked to this category. Philadelphia County was evaluated on 4 Items, compliant on 1 Item, and partially compliant on 3 Items.
Effectuation of Reversed Resolutions 438.424	Partial	4 Items were crosswalked to this category. Philadelphia County was evaluated on 4 Items, compliant on 1 Item, and partially compliant on 3 Items.

Based on the Items reviewed, Philadelphia County was fully compliant on one of the 10 evaluated categories of Federal and State Grievance System Standards regulations and partially compliant on the other nine categories. The category Recordkeeping and Recording Requirements was compliant per the 2009 Encounter Monthly Aggregate Complaint/Grievance Records (EMG) and Encounter Monthly Complaint/Grievance Synopsis Records (MCG) tracking reports. In all, 56 PEPS Items were crosswalked to Federal and State Grievance System Standards and Philadelphia County was evaluated on all 56 Items. Philadelphia County was fully compliant on 33 Items and partially compliant on 23 Items. As stated previously, some PEPS standards are crosswalked to more than one category.

Philadelphia County was rated partially compliant on nine of the 10 categories pertaining to Federal State and Grievance System Standards due to partial compliance with substandards of PEPS Standards 71 and 72.

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.

The partial compliance determination for Philadelphia County was:

Philadelphia County was partially compliant on two substandards of Standard 71: #1 and #2 (RY 2007).



Substandard 1: Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process including how grievance rights and procedures are made known to members, BH MCO staff and the provider network (BBA Fair Hearing, 1st level, 2nd level, External, Expedited).

Substandard 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.

PEPS Standard 72: See Standard description and non-compliant substandards determination under Coverage and Authorization of Services.

Program Evaluation Performance Summary OMHSAS-Specific Items for CBH and Philadelphia County

In RY 2009, 11 Items were considered OMHSAS-specific monitoring standards, and nine were reviewed although not required to fulfill BBA requirements. Of the 11 OMHSAS-specific PEPS Items, nine were evaluated for CBH/Philadelphia County. Table 1.5 provides a count of these Items, along with the relevant categories.

Table 1.5 OMHSAS-Specific Items Reviewed for CBH

Category (PEPS Standard)	Total # of Items	PEPS Reviewed in RY 2009	PEPS Reviewed in RY 2008	PEPS Reviewed in RY 2007	Not Reviewed
Second Level Complaints and Grievances					
Complaints (Standard 68)	4	0	0	3	1
Grievances and State Fair Hearings (Standard 71)	4	0	0	3	1
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	3	0	0

Format

This document groups the monitoring standards under the subject headings Second Level Complaints and Grievances, and Enrollee Satisfaction. The status of each Item is presented as it appears in the PEPS tools submitted by the Commonwealth (i.e., met, partially met, or not met). 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 Items relating to second level complaints and grievances are MCO-specific review standards. CBH was evaluated on six of the eight applicable standards. Of the six standards evaluated, CBH met two standards, partially met two standards, and did not meet two standards, as seen in Table 1.6.

Table 1.6 OMHSAS-Specific Requirements Relating to Second Level Complaints and Grievances

Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
Complaints	Standard 68.4	RY 2007	Met
	Standard 68.5	RY 2007	Partially Met
	Standard 68.6	RY 2007	Not Met



Category	PEPS Item	Review Year	Status
Second Level Complaints and Grievances			
	Standard 68.7	RY 2007	Not Evaluated
Grievances and State Fair Hearings	Standard 71.3	RY 2007	Met
	Standard 71.4	RY 2007	Partially Met
	Standard 71.5	RY 2007	Not Met
	Standard 71.6	RY 2007	Not Evaluated

Note: Substandards 68.4, 68.5, 68.6, and 68.7 from RY 2007 and RY 2008 were re-numbered as Substandards 68.6, 68.7, 68.8, and 68.9, respectively, in the RY 2009 PEPS tools. Substandards 71.3, 71.4, 71.5, and 71.6 from RY 2007 and RY 2008 were re-numbered as Substandards 71.5, 71.6, 71.7, and 71.8, respectively, in the RY 2009 PEPS tools.

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.

CBH was “partially met” on Substandard 68.5 (RY 2007; numbered as Substandard 68.7 in RY 2009):

Substandard 68.5: Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.

CBH was “not met” on Substandard 68.6 (RY 2007; numbered as Substandard 68.8 in RY 2009):

Substandard 68.6: 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.

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.

CBH was “partially met” on Substandard 71.4 (RY 2007; numbered as Substandard 71.6 in RY 2009):

Substandard 71.4: Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.

CBH was “not met” on Substandard 71.5 (RY 2007; numbered as Substandard 71.7 in RY 2009):

Substandard 71.5: 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.

The OMHSAS-specific PEPS Items relating to Consumer/Family Satisfaction are County-specific review standards. Of these Items, three were evaluated for Philadelphia County. Philadelphia County met all three Items, as seen in Table 1.7.

Table 1.7 OMHSAS-Specific Requirements Relating to Enrollee Satisfaction

Category	PEPS Item	Review Year	Status
Enrollee Satisfaction			
Consumer/Family Satisfaction	Standard 108.3	RY 2008	Met
	Standard 108.4	RY 2008	Met
	Standard 108.9	RY 2008	Met



II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of one PIP for each HealthChoices BH MCO. Under the existing 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 2010 for 2009 activities.

A new EQR PIP cycle began for BH MCOs and Counties in 2008. For this new 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 have been noted, aggregate FUH rates have remained below the benchmark of 90% established by OMHSAS. FUH for the Medicaid Managed Care (MMC) population continues to be an area of concern for OMHSAS.

The 2010 EQR is the seventh 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 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 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 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 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 2009. At the time of the review, a project can be reviewed for only a few elements. It will then be evaluated for other elements at a later date, 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, and 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, PH MCOs were required to submit information for review elements two through five, Topic Relevance through Baseline Study Population and Baseline Measurement Performance. CBH submitted all required elements of the FUH PIP for review.

The project had previously received full credit for Topic Selection. This element was 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, CBH 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 measure 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, 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, plus 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 additional codes for inclusion. OMHSAS has determined that the rates calculated for Measurement Year (MY) 2008 using these four indicators will be used as baseline measurements for all Counties/BH MCOs for the current PIP study cycle.

The rationale provided for this activity selection was based primarily on a root cause analysis conducted using inpatient data from January 2006 to August 2009. CBH examined patterns among members who were frequent utilizers of inpatient care, reviewing both recidivism and follow-up/utilization. CBH profiled member records in each of four categories according to frequency of inpatient episodes within the period, and calculated follow-up rates within 30 days, average length of stay (ALOS), and total associated costs of stay for each category. The MCO also examined the effects of mental health and drug and alcohol (D&A) utilization, crisis response center (CRC) episodes, days in involuntary commitment admissions, extended acute care, intensive care managers (ICMs), resource coordinator utilization, and rehabilitation and detoxification services utilization on the number of days in acute inpatient (AIP) psychiatric care. Through regression modeling, CBH observed that overall outpatient services did not impact or reduce subsequent inpatient episodes or inpatient days for its membership population.

Given this unexpected finding, and proposing that appropriate follow-up care should reinforce gains from inpatient treatment and reduce the need for additional inpatient stays, CBH conducted additional analyses to examine suboptimal follow-up rates. CBH examined where members go for next level of care after discharge from AIP, analyzing the level of care for members who received follow-up services within seven



days of discharge, members who received follow-up services between eight and 30 days, and members who did not receive follow-up services within 30 days of discharge. CBH found that the levels of care ranged from intensive case management to individual mental health treatment as examples of services for those with follow-up within seven days of discharge whereas CRC evaluations and inpatient (both voluntary and involuntary) admissions were found for those members who did not receive follow-up services within 30 days of discharge. CBH concluded that these findings suggest that the longer clients go without follow-up treatment in the community post-discharge, the more likely they are to receive higher intensity levels of care after discharge.

As a result of these additional analyses, CBH also made a number of other observations about its member population and the services they receive after hospitalization. CBH observed that 14% of members who received follow-up care within 30 days of discharge visited ICMs as the first point of outpatient contact post-discharge. CBH noted that these findings may explain why their PA-specific indicator rates are uniformly higher than the HEDIS indicator rates for the measure, but that the heavy reliance on ICMs is problematic. The BH MCO acknowledged that although timely outpatient connections to resources such as ICMs are associated with positive outcomes, they are not adequate substitutes for ambulatory treatments. Therefore, CBH recognizes the need to improve follow-up rates with respect to active treatment services to avoid readmission to more intensive levels of care. Additionally, CBH noted that a disproportionate number of members with both mental health and substance abuse (“co-occurring”) disorders are admitted to acute psychiatric inpatient units where they receive minimal or no attention to their substance abuse issues and are then discharged with recommendations to follow up at outpatient mental health centers, rather than at substance abuse or co-occurring programs. CBH continued that these members are frequently not screened for drug use in the CRCs prior to acute psychiatric inpatient admissions and are misdiagnosed with primary mental health disorders rather than substance abuse disorders with behavioral symptoms.

Baseline results were calculated in 2009 for the period January 1, 2008 through December 31, 2008 and were previously presented along with analysis that would lead to interventions initiated in late 2009. The baseline results indicated a rate of 34.8% for QI 1 (HEDIS – seven days), 51.2% for QI 2 (HEDIS – 30 days), 52.0% for QI A (PA-Specific – seven days), and 67.4% for QI B (PA-Specific – 30 days). Rates for all indicators were below the 90% benchmark established by OMHSAS. After review of the validated data and comparing them to previous years’ rates, the CBH Director of Continuous Quality Improvement (CQI) along with other CQI Department staff conducted a more detailed analysis of follow-up rates after inpatient hospitalization. This, in conjunction with the root cause analysis led the CQI Department to look more closely at HEDIS rates. CBH noted that the HEDIS definition allows only outpatient treatment and not intake visits or assessments, which can impact the rates. This issue, however, is not a barrier that can be addressed by the MCO, as the national HEDIS definition has been required for use by OMHSAS for QIs 1 and 2. CBH’s barrier analysis also examined concerns noted by CQI staff over the last several years regarding members receiving timely intake appointments and then waiting long periods of time for actual therapy to begin. CQI staff noted that during some of those “wait” periods, members were re-hospitalized before they could see a therapist or that they never attended either intake or therapy sessions. Additionally, CBH outlined several barriers as a result of these analyses, some of which the MCO had already identified as part of its root cause analysis. The additional barriers identified by CBH included: 1) variation by provider in obtaining appointments and communicating specific appointment information to CBH, 2) inconsistent use of discharge screen tool by clinical care managers, which has made outreach to members regarding follow-up care more difficult, 3) long outpatient wait lists, 4) delays in appropriate discharge planning, 5) inadequate identification of and communication with existing outpatient providers, and 6) members’ lack of perceived need for follow-up services. Based on the review of baseline results, CBH developed an extensive list of interventions to be implemented in late 2009 and early 2010.

CBH received full credit for the elements of the study evaluated that reflects activities in 2009 (Topic Relevance through Baseline Study Population and Baseline Measurement Performance). Interventions Aimed at Achieving Demonstrable Improvement will be evaluated in 2011, based on activities conducted in 2010.



**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)	Not Determined	20%	TBD
7. Demonstrable Improvement (CY 2010, reported in 2011)	Not Determined	20%	TBD
Total Demonstrable Improvement Score			TBD
1S. Subsequent or modified Interventions Aimed at Achieving Sustained Improvement (07/2010 through 06/2011)	Not Determined	5%	TBD
2S. Sustained Improvement (CY 2011, reported in 2012)	Not Determined	15%	TBD
Total Sustained Improvement Score			TBD
Overall Project Performance Score			TBD

**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)	34.8%	NA	TBD	TBD	90%
HEDIS Indicator: Follow-up After Hospitalization for Mental Illness within 30 days after discharge (QI 2)	51.2%	NA	TBD	TBD	90%
PA-Specific Indicator (Initial): Follow-up After Hospitalization for Mental Illness within seven days after discharge. (Standard HEDIS Codes and PA codes) (QI A)	52.0%	NA	TBD	TBD	90%
PA-Specific Indicator (Initial): Follow-up After Hospitalization for Mental Illness within 30 days after discharge. (Standard HEDIS Codes and PA codes) (QI B)	67.4%	NA	TBD	TBD	90%
Project Status	Baseline Study	Interventions	Remeasurement #1	Remeasurement #2	



III: PERFORMANCE MEASURES

In 2010, 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 and BH MCO rates to available national benchmarks and to prior years' rates.

In MY 2002, the initial measurement year, IPRO and OMHSAS worked together to adapt the measures from the HEDIS methodology, allowing for a significant reduction in the time period needed for indicator development. Senior medical staff at IPRO reviewed the adapted methodology in detail to ensure consistency was maintained with regard to the specifications. Project management staff at both IPRO and OMHSAS also collaborated extensively during the indicator development phase, especially with regard to which local PA codes were considered for inclusion in the list of qualifying procedure codes, while still maintaining consistency with the HEDIS measure specifications. In addition to the adapted indicators, OMHSAS expanded the measures to include services with high utilization in the HealthChoices program. For MY 2002, since two codes of interest could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits, QI 3 and QI 4 were developed to capture these codes, while still generating rates for measures (i.e., QIs 1 and 2) that could be compared to national benchmarks. For the second re-measure in MY 2004, the indicator specifications were updated to reflect changes in the HEDIS 2005 Volume 2, Technical Specifications and four more local codes were added – to bring the total to six – to QIs 3 and 4. OMHSAS staff provided IPRO with a PA local code to national code mapping document to assist in this regard. The MY 2005 re-measure saw very few changes to the measure specifications, of which the main change to the methodology involved the exclusion of an expired PA local code. The MY 2006 re-measure, however, saw significant changes to QI 3 and QI 4 from prior years. 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 updated 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 – Lackawanna, Luzerne, Susquehanna, and Wyoming. These Counties were asked to collect data for the six-month time frame that they were in service for 2006 (July to December). In effect, MY 2006 was a baseline measurement year for collection of QIs A and B, and for the Northeast region across all indicators.

For MY 2007, the indicator specifications were updated to reflect changes in the HEDIS 2008 Volume 2, Technical Specifications. The primary change was the addition of a POS code requirement to select CPT codes in the HEDIS and PA-specific measure specifications. In addition, all PA local codes previously mapped to standard CPT and HCPCS codes as per HIPAA requirements were retired and removed. For the study, the follow-up measure was implemented for the 23 North/Central State Option Counties implemented in January 2007, and the 15 North/Central County Option Counties implemented in July 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 (July to December).



For MY 2008, indicator specifications were again aligned to the HEDIS 2009 Volume 2, Technical Specifications. Two procedure codes (one CPT and one HCPCS code) to identify eligible follow-up visits were added to the PA-specific measures per suggestions from OMHSAS, the Counties, and the BH MCOs. These codes were added to the existing 17 PA-specific codes, totaling 19 additional service codes that distinguish the PA-specific measure from the HEDIS measure in the MY 2008 study. Furthermore, as requested by OMHSAS, the MY 2008 findings by age are 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 studies including MY 2007. As a result, the population previously reported as two cohorts are combined for comparative purposes.

For the current study using MY 2009 data, the indicators had few changes based on the HEDIS 2010 Volume 2: Technical Specifications. The primary change was the removal of CPT codes that were no longer valid, and the addition of several HCPCS codes. With regard to reporting, as requested by OMHSAS, all data analyses by region were removed, since the regional characteristics have become increasingly geographically diverse and the associated Counties are non-contiguous as the HealthChoices program has expanded beyond the initial legacy regions (Leigh/Capital, Southeast, and Southwest) over the years of re-measuring this performance indicator.

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 2009 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, 2009;
- 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.

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 long standing 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.

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 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 2009 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.

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. 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 2008 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 and denominator 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% 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 2009 HEDIS Indicator Rates with Year-to-Year Comparisons

	MY 2009							MY 2008	RATE COMPARISON MY 2009 to MY 2008	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI 1										
HealthChoices	16,393	35,975	45.6%	45.1%	46.1%	45.2%	48.5%	43.3%	2.3	YES
CBH/ Philadelphia	2,854	8,215	34.7%	33.7%	35.8%			34.8%	-0.1	NO
QI 2										
HealthChoices	23,601	35,975	65.6%	65.1%	66.1%	65.4%	70.8%	63.7%	1.9	YES
CBH/ Philadelphia	4,196	8,215	51.1%	50.0%	52.2%			51.2%	-0.1	NO

The MY 2009 HealthChoices rates were 45.6% for QI 1 and 65.6% for QI 2. Both rates were statistically significantly higher than MY 2008. CBH's MY 2009 rate for QI 1 was 34.7%, and QI 2 rate was 51.1%. Although absolute decreases were noted for both rates as compared to MY 2008, the changes were not statistically significant.

For MY 2009, CBH's QI 1 rate of 34.7% was statistically significantly lower than the QI 1 HealthChoices BH MCO Average of 45.2% by 10.5 percentage points. CBH's QI 2 rate of 51.1% was also statistically significantly below the QI 2 HealthChoices BH MCO Average of 65.4% by 14.3 percentage points. Overall, CBH observed the lowest QI 1 and QI 2 rates among the five BH MCOs evaluated in MY 2009.



For MY 2009, CBH was subcontracted to provide behavioral health services to only one County located in the Southeast region of the Commonwealth: Philadelphia County. Therefore, the CBH performance comprises the BH MCO performance for Philadelphia County alone. Figure 3.1 displays a graphical representation of the MY 2009 HEDIS follow-up rates for Philadelphia County. In MY 2009, Philadelphia (34.7%) performed statistically significantly below the QI 1 HealthChoices County Average of 48.5% by 13.8 percentage points. For QI 2, Philadelphia (51.1%) was statistically significantly below the HealthChoices County Average of 70.8% by 19.7 percentage points.

Figure 3.1 MY 2009 HEDIS Indicator Rates

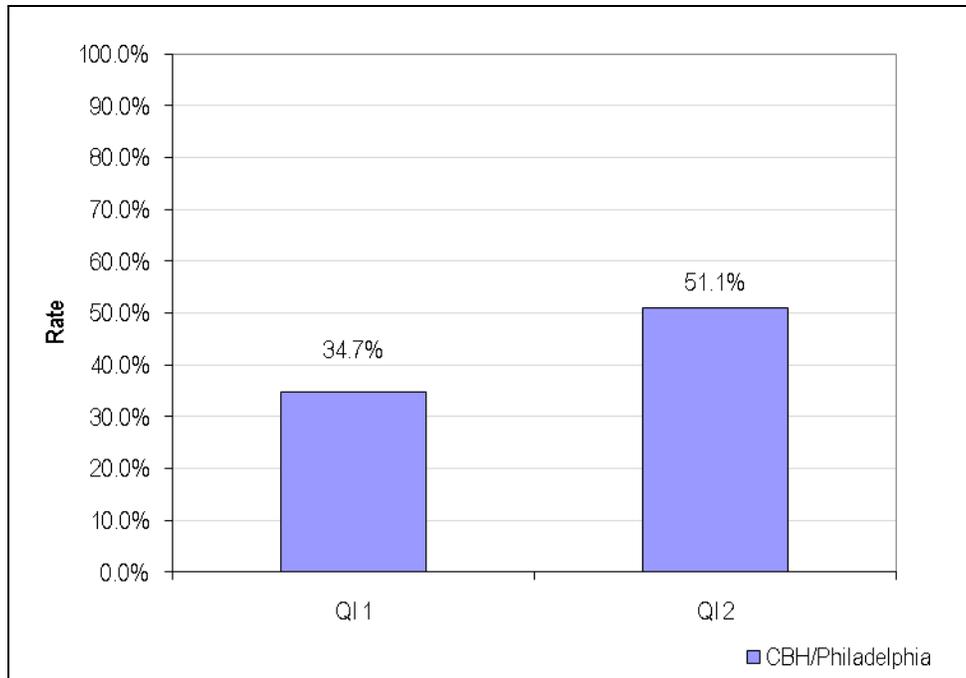


Table 3.2 MY 2009 PA-Specific Indicator Rates with Year-to-Year Comparisons

	MY 2009							MY 2008	RATE COMPARISON MY 2009 to MY 2008	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
QI A										
HealthChoices	21,203	35,975	58.9%	58.4%	59.4%	58.6%	60.5%	56.9%	2.0	YES
CBH/Philadelphia	4,349	8,215	52.9%	51.9%	54.0%			52.0%	0.9	NO
QI B										
HealthChoices	26,984	35,975	75.0%	74.6%	75.5%	74.8%	77.5%	73.3%	1.7	YES
CBH/Philadelphia	5,583	8,215	68.0%	66.9%	69.0%			67.4%	0.6	NO

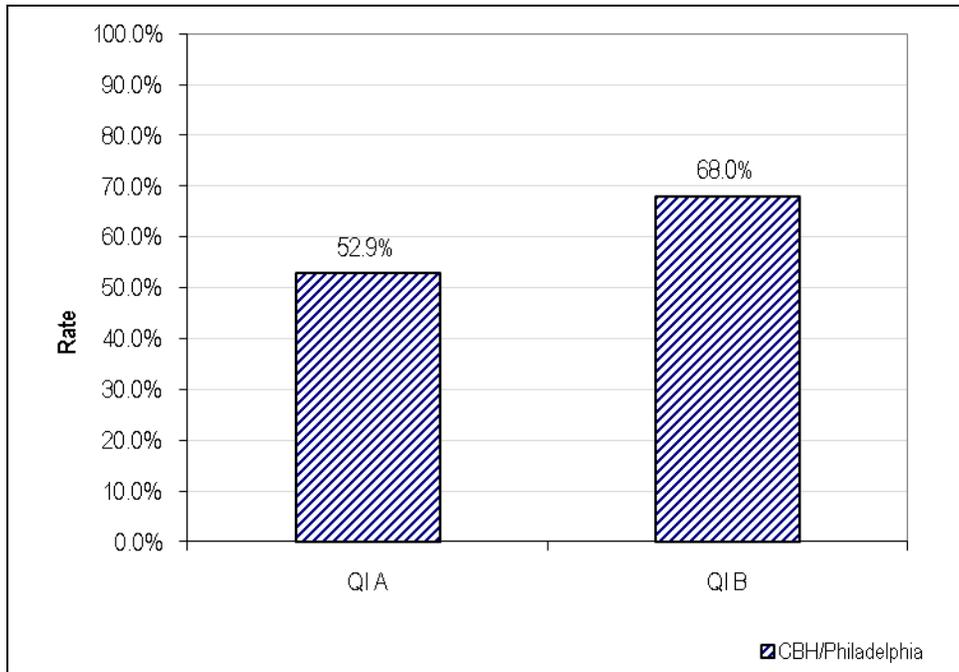
The MY 2009 HealthChoices rates were 58.9% for QI A and 75.0% for QI B. Year-to-year increases from MY 2008 were statistically significant for both indicators. From MY 2008 to MY 2009, CBH evidenced slight absolute percentage point increases that were not statistically significant for either the QI A and QI B rates.



For MY 2009, CBH's QI A rate of 52.9% was statistically significantly lower than the QI A HealthChoices BH MCO Average of 58.6% by 5.7 percentage points. CBH's QI B rate of 68.0% was also statistically significantly below the QI B HealthChoices BH MCO Average of 74.8% by 6.8 percentage points. Overall, CBH observed the lowest QI A and QI B rates among the five BH MCOs evaluated in MY 2009.

Figure 3.2 displays a graphical representation of the MY 2009 PA-specific follow-up rates for Philadelphia. At 52.9% for QI A, Philadelphia was statistically significantly below the HealthChoices County Average of 60.5% by 7.6 percentage points. At 68.0% for QI B, Philadelphia was statistically significantly below the HealthChoices County Average of 77.5% by 9.5 percentage points.

Figure 3.2 MY 2009 PA-Specific Indicator Rates



Comparison to HEDIS® Medicaid Benchmarks

The HealthChoices HEDIS indicator rates and BH MCO rates were compared to the *HEDIS 2009 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 is generated annually using HMO, POS, and HMO/POS combined products from MCOs that underwent a HEDIS Compliance Audit™. Data were included from MCOs, regardless of whether the MCO did or did not report individual HEDIS rates publicly. The means and percentiles displayed in the *HEDIS 2009 Audit Means, Percentiles and Ratios* tables are based on data from the 2008 measurement year. The benchmark values are presented in Table 3.3.



Table 3.3 HEDIS 2009 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	42.6	15.5	31.6	44.5	56.6	64.2
Follow-up After Hospitalization for Mental Illness – 30 Days	61.7	37.3	49.6	64.3	75.7	81.2

For MY 2009, the HealthChoices rates were 45.6% for QI 1 and 65.6% for QI 2. As compared to the HEDIS 2009 Medicaid benchmarks, the rates for both QI 1 and QI 2 fell between the 50th and 75th percentiles. For MY 2008, the QI 1 rate of 43.3% fell between the 50th and 75th percentiles, and the QI 2 rate of 63.7% fell between the 25th and 50th percentiles of the HEDIS 2008 Medicaid benchmarks.

When comparing the MY 2009 CBH rates to the HEDIS benchmarks, the QI 1 rate of 34.7% and QI 2 rate of 51.1% both fell between the 25th and 50th percentiles of the respective measure's benchmarks. In MY 2008, the BH MCO's QI 1 rate of 34.8% fell between the 25th and 50th percentiles, and QI 2 rate of 51.2% fell between the 10th and 25th percentile ranges of the HEDIS 2008 Medicaid benchmarks.

BH MCO rates for various breakouts including race, ethnic groups, age cohorts, and gender were provided in the Follow-up After Hospitalization for Mental Illness EQR final report.

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 2010 study, which represented results for MY 2009, 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 and the MCOs of the effectiveness of the interventions implemented between MY 2008 and MY 2009 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 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 2008 and MY 2007. The Counties 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 there were increases in follow-up rates in MY 2009 as compared to previous measurement years. Disparities in rates between demographic populations, however, continue to persist as seen in prior studies. It is clear that the OMHSAS contracted Counties and their subcontracted BH MCOs are working to improve their overall follow-up rates, but it is 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 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, or with co-occurring conditions such as substance abuse and/or addiction. After evaluating the BH MCO data for trends, subject-specific findings should be transmitted to BH MCO and/or County care managers for implementation of appropriate action.

Additional recommendations for the 67 Counties and their subcontracted MCOs can be found in the 2010 Follow-up After Hospitalization for Mental Illness EQR final report.

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. The MY 2009 study conducted in 2010 was the third re-measurement of this indicator, and the indicator specification had no significant changes as compared to MY 2008. This measure continued to be of interest to OMHSAS for the purposes of comparing County and BH MCO rates to the OHMSAS performance goal and to baseline rates.

This study examined behavioral health services provided to members participating in the HealthChoices Mandatory MMC BH 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 2009 study.

Eligible cases were defined as those members in the HealthChoices 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, 2009;
- 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.

Performance Goals

OMHSAS designated the performance measure goal as better (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 for when multiple Counties contract with a single BH MCO. Year-to-year comparisons of MY 2009 to MY 2008 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 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 2009 Readmission Rates with Year-to-Year Comparisons

	MY 2009							MY 2008	RATE COMPARISON MY 2009 to MY 2008	
	(N)	(D)	%	LOWER 95% CI	UPPER 95% CI	HEALTH- CHOICES BH MCO AVERAGE	HEALTH- CHOICES COUNTY AVERAGE	%	PPD	SSD
HealthChoices	5,797	48,019	12.1%	11.8%	12.4%	12.3%	10.5%	12.8%	-0.7	YES
CBH/Philadelphia	1,499	11,618	12.9%	12.3%	13.5%			12.8%	0.1	NO

The aggregate MY 2009 HealthChoices readmission rate was 12.1%. This rate was a statistically significant decrease (improvement) of 0.7 percentage points from the MY 2008 rate of 12.8%. CBH/Philadelphia's rate was higher (poorer) than the HealthChoices BH MCO Average of 12.3%, but the difference was not statistically significant. Note that this measure is an inverted rate, in that lower rates are preferable. Overall, the rate for CBH/Philadelphia did not meet the performance goal in MY 2008.

Figure 3.3 displays a graphical representation of the MY 2009 readmission rates for CBH/Philadelphia County. Figure 3.4 shows Philadelphia County's rate as compared to the HealthChoices County Average. For MY 2009, the rate for Philadelphia (12.9%) was statistically significantly higher (poorer) than the HealthChoices County Average of 10.5% by 2.4 percentage points.

Figure 3.3 MY 2009 Readmission Rates

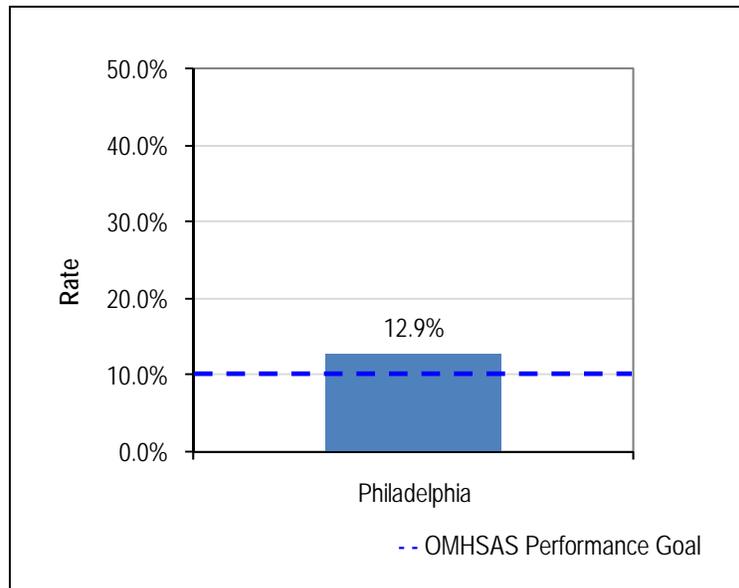
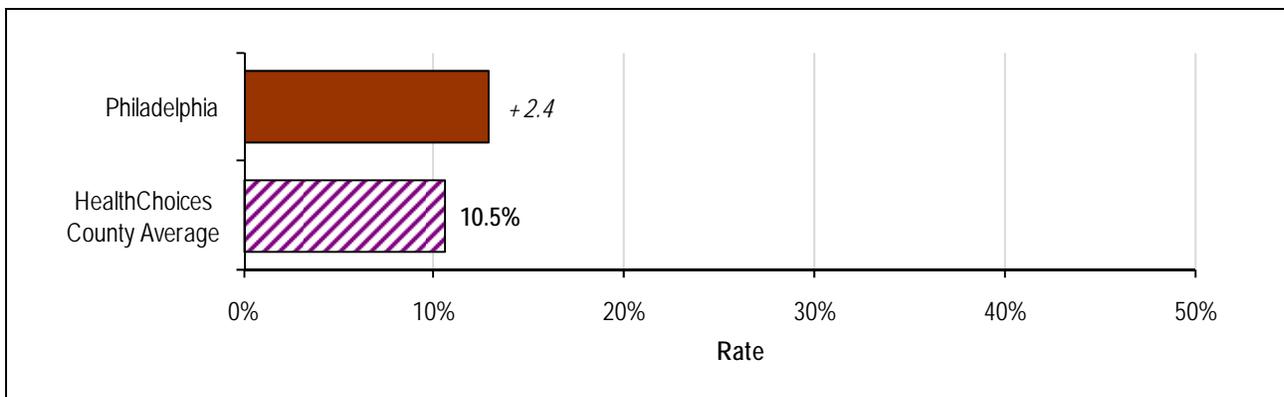


Figure 3.4 MY 2009 Rates Compared to HealthChoices County Average



Conclusion and Recommendations

The study concluded that continued efforts should be made to improve performance with regard to Readmission within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH MCOs such as CBH 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 Readmission within 30 Days of Inpatient Psychiatric Discharge final report.

In response to the MY 2009 study, the following general recommendations were made to all five participating BH MCOs:



- IPRO recommends continued annual evaluation of Inpatient Readmission after Psychiatric Discharge rates for OMHSAS contracted Counties and their subcontracted BH MCOs. Ongoing comparison of current year rates to prior years' performance should also be assessed to determine the extent to which BH MCOs and Counties are able to improve their readmission rates and meet or exceed the OMHSAS set performance measure goal.
- The Counties and BH MCOs participating in this study should evaluate the current interventions in place to assess how these interventions affected change in readmission rates from MY 2008 and MY 2007. Additionally, current interventions should be assessed to determine whether they should be continued, abandoned and/or expanded in order to have a greater impact on their respective inpatient acute readmission rates when re-measured for MY 2010.
- Given that none of the BH MCOs met the performance goal for MY 2009, BH MCOs are encouraged to make Inpatient Readmission After Psychiatric Discharge a focus for ongoing quality improvement activity.
- The BH MCOs and Counties are encouraged to conduct root cause analyses to help determine what factors are negatively impacting readmission rates.
- BH MCO and County case review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended. The additional review should among other things determine the extent to which those individuals had evidence of ambulatory follow-up/aftercare visit(s) during the interim period.
- 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 MCO and Counties are encouraged to review the findings of the readmission study in conjunction with follow-up after hospitalization rates.
- 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.
- BH MCOs and Counties that have demonstrated a statistically significant decline in readmission for MY 2009 should be asked to share best practices with other entities with the hope of identifying interventions that result in performance improvement.
- BH MCOs, especially those that operate in or represent Counties in close proximity, are encouraged to work on this issue collaboratively.
- Disparities in rates between demographic populations continue to persist. It is important for each BH MCO to continue to target interventions to 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.

IV: 2009 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 2009 EQR Technical Reports, which were distributed in May 2010. The 2010 EQR Technical Report is the third report to include descriptions of current and proposed interventions from each BH MCO that address the 2009 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, 2010 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 October 2010, as well as any additional relevant documentation provided by CBH.

Table 4.1 Current and Proposed Interventions: Opportunities for Improvement

Reference Number	Opportunity for Improvement	MCO Response
Structure and Operations Standards		
CBH 1	CBH was deemed partially compliant on seven of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories were: 1) Availability of Services (Access to Care),	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>Please see PEPS 2009 documentation.</p>  <p>PEPS2009.pdf</p> <p>Meeting with CBH Member Services Director to design provider self-report mechanism, Sept 23, 2010.</p> <p>Please see attached CBH PEPS 2009 documentation for standards 28 and 93, which include follow-up action.</p> <p>PEPS Standard 28, sub-standard 2: This standard was addressed in the CBH 2009 PEPS report under Standard 28.2 (PEPS pp. 38- 40) and under Standard 93.1 and 93.2 (PEPS pp. 99-106). (Analysis of Outpatient provider wait times and sharing with CBH Member Services) (Clinical chart audits of cases)</p> <p><u>Future Actions Planned</u></p> <p>Develop Routine "Exception Reports" for Member Services to Run Monthly for</p>

Reference Number	Opportunity for Improvement	MCO Response
		<p>Average Wait Times Beyond 7 Days for outpatient (OP) Providers. Draft Specifications created September 2010. Awaiting approval for implementation.</p> <p>Develop Routine "Exception Reports" for Member Services to Run Monthly for Members Who Do Not Receive an Appt. w/a Physician (Psych or Medical) w/in 30 Days Draft Specifications created September 2010. Awaiting approval for implementation.</p>
	<p>2) Coordination and Continuity of Care,</p>	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>Please see PEPS documentation for follow-up actions.</p> <p>PEPS Standard 28, Sub-standard 2: This standard was addressed in the CBH 2009 PEPS report under Standard 28.2 (PEPS pp. 38- 40) and under Standard 93.1 and 93.2 (PEPS pp. 99-106). Please see Root Cause Analysis for Follow-up After Hospitalization for Mental Illness.</p> <p> Follow-Up Root Cause Rewrite 06042</p> <p><u>Future Actions Planned</u></p> <p>Please see Root Cause Analysis for Follow-Up After Hospitalization for Mental Illness Hospitalization</p>
	<p>3) Coverage and Authorization of Services,</p>	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>Screen data collection developed for IS system. Pilot began Sept, 2010.</p> <p>PEPS Standard 28, Sub-standard 2: This standard was addressed in the CBH 2009 PEPS report under Standard 28.2 (PEPS pp 38-40) and under Standard 72.1 (PEPS pp.69, 107-111 and DOH CAP Completion letter - attached).</p> <p><u>Future Actions Planned</u></p> <ul style="list-style-type: none"> • Finalize Drug Screens and track their use by Care Managers via Standard Reports. October 2010 and ongoing. • Clinical Care Audits re-designed and implemented August, 2010. Final results expected December 2010. • Department of Health (DOH) corrective action plan (CAP) on Denial Letters resolved and in monitoring stages since June 2010. • Results of monitoring forwarded directly to DOH monthly. • Physician Documentation audits revised, completed and analyzed August, 2010.
	<p>4) Provider Selection,</p>	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>Please see DOH CAP submission for follow-up actions and future actions planned with dates.</p>

Reference Number	Opportunity for Improvement	MCO Response
		 DOH CAPLTR.pdf PEPS Standard 10, Sub-standards 10.1 and 10.3: This standard was addressed in the CBH 2009 PEPS report under Standard 10.1 (PEPS p.22) and Standard 10.3 (PEPS p. 22) and DOH CAP resolution notification December 3, 2009. <u>Future Actions Planned</u> Please see DOH CAP submission for follow-up actions and future actions planned with dates.
	5) Subcontractual Relationships and Delegation,	<u>Follow Up Actions Taken Through 09/30/10</u> Please see PEPS documentation (PEPS pp.51-68). Continue to develop and distribute individual provider profile reports by level of care throughout 2010. Added Pay for Performance incentives based on profiles September 2010 and ongoing. Issue 2009 Series Inpatient Provider Profile Reports September 2010. PEPS Standard 99, Sub-standards 99.1, 99.5 and 99.8. Standard 99.1 and 99.5 were addressed in the CBH 2009 PEPS report under Standard 68 (PEPS pp.51-68) and under Standard 99.8 (PEPS p. 122). Please see attached PowerPoint (P4P Update Exec Directors Oct_5_2010.ppt)  P4PUpdate_ExecDir_ Oct 5 2010.ppt <u>Future Actions Planned</u> <ul style="list-style-type: none"> • Issue 2009 Series residential treatment facility (RTF) Provider Profile Reports October 2010. • Issue Detox/Rehab Provider Profile Reports December 2010. • All of above Provider Profile reports include Provider Self-Audit tools to be validated by CBH Credentialing staff upon site visits. Development of Provider Self-Audit Tools complete July 2010. • Develop targeted case management (TCM) Provider Profile Reports January 2011.
	6) Practice Guidelines, and	<u>Follow Up Actions Taken Through 09/30/10</u> Analysis of case audit results and sharing with Clinical Management completed July 2010. High Utilizer workgroups ongoing. Creation of Special Needs team approved Sept. 2010. Piloting to begin October 2010. Staff hired for Special Needs Team. Data analysis began July 2010 and ongoing. Clinical Audit Tool redesigned and approved August 2010.



Reference Number	Opportunity for Improvement	MCO Response
		<p>PEPS Standard 28, Sub-standard 2 and PEPS Standard 93, Sub-standards 1 & 2. Standard 28.2 was addressed in CBH 2009 PEPS report (PEPS pp. 38-40) and under standards 93.1 (PEPS p. 99) and 93.2 (PEPS p.104).</p> <p><u>Future Actions Planned</u></p> <p>Repeat clinical case audit September-December 2010. Final results and analysis expected by December 31, 2010</p>
	<p>7) Quality Assessment and Performance</p> <p>Improvement Programs. Of the 68 Items evaluated for Subpart D: Quality Assessment and Performance Improvement Regulations, nine (13%) were deemed non-compliant.</p>	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>For Standard 93.1, continue to monitor Crisis Response Center wait times.</p> <p>PEPS Standard 93, Sub-standards 1 & 2; PEPS Standard 98, Sub-standard 1: Standards 93.1 and 93.2 were addressed in the CBH 2009 PEPS report (PEPS pp. 99-112). Standard 98.1 was addressed in the CBH 2009 PEPS report (p. 119-121).</p> <p><u>Future Actions Planned</u></p> <p>Also, please see documentation for Exception reports under #5 above.</p>
<p>CBH 2</p>	<p>CBH was deemed partially compliant on nine of the 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. These partially compliant categories were:</p> <ol style="list-style-type: none"> 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions. 	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>CBH 2009 PEPS analysis showed Quality Management's Complaints and Grievances procedures to be 100% compliant with PEPS Standards PEPS pp. 51-68). Maintain 100% compliance with Standards.</p> <p>CBH Quality Management did not receive feedback from DOH on results of Corrective Action Plan in 2009.</p> <p>PEPS Standard 71, Sub-standards 1, 2, 4, & 5; PEPS Standard 72, Sub-standard 1; PEPS Standard 68, Sub-standards 5 & 6: Standards 71.1, 71.2, 71.4 & 71.5 were addressed in the CBH 2009 PEPS Report (PEPS pp. 60-67); Standard 68.1 was addressed in the CBH 2009 PEPS Report (PEPS p. 107 and DOH CAP); PEPS Standard 68.5 & 68.6 (under Standard 68.2 (PEPS p. 52) PEPS pp. 58 & 59).</p> <p><u>Future Actions Planned</u></p> <p>Continue to submit monitoring reports to DOH.</p>
<p>Performance Measures</p>		
<p>CBH 3</p>	<p>CBH's rates for the MY 2008 Follow-up After Hospitalization for Mental Illness HEDIS indicators, QI</p>	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>High Utilizer Workgroup convened (Including CBH & Philadelphia Office of Mental Health). Data analysis and discussion ongoing June 2010 and ongoing. Special</p>

Reference Number	Opportunity for Improvement	MCO Response
	<p>1 and QI 2, were statistically significantly lower than the respective HealthChoices BH MCO Averages. The QI 1 rate of 34.8% was statistically significantly lower than the HealthChoices BH MCO QI 1 Average of 43.5% by 8.7 percentage points. CBH's QI 2 rate of 51.2% was also statistically significantly below the HealthChoices BH MCO Average of 64.0% by 12.8 percentage points.</p>	<p>Needs team created and staff hired, Sept. 2010. Piloting to begin October 2010.</p> <p>Please see Root Cause Analysis for Follow-Up After Hospitalization for Mental Illness, submitted June 7, 2010.</p> <p>This item addressed in CBH 2009 PEPS Report under PEPS Standard 91.10 (PEPS p. 80-81).</p> <p>This item addressed in CBH Fourth Quarter PIP submission (May 19, 2010) to OMHSAS (please see attached).</p> <p> PIPs Report 4Q2009 05_19_10.doc</p> <p>Pay-for-Performance standards set to encourage provider collaboration and improvement plans that would affect these measures esp. for the adult population. Child measures were within standards.</p> <p><u>Future Actions Planned</u></p> <p>Development of System Alerts and automatic (every 6 months) updates for Special Needs team referral, Physician reviews and Care Planning. June –December 2010.</p> <p>Please see attached flow chart for special needs referrals and Power Point Presentation on High Utilizers Cluster Analysis.</p> <p>  Special Needs Flow Chart 09292010.doc HighUtilizersClusterA nalysis.2010-06-08.p</p>
CBH 4	<p>CBH's rates for both MY 2008 Follow-up After Hospitalization for Mental Illness PA-specific indicators were statistically significantly lower than the corresponding HealthChoices BH MCO Averages. The QI A rate of 52.0% was statistically significantly lower than the HealthChoices BH MCO QI A Average of 56.8% by 4.8 percentage points. CBH's QI B rate of 67.4% was also statistically significantly below the HealthChoices BH MCO Average of 73.2% by 5.8 percentage points.</p>	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>Please See MCO Response to HEDIS Follow-Up Measures above.</p> <p><u>Future Actions Planned</u></p> <p>Please See MCO Response to HEDIS Follow-Up Measures above.</p>

Reference Number	Opportunity for Improvement	MCO Response
CBH 5	CBH's MY 2008 rate for the Readmission within 30 Days of Inpatient Psychiatric Discharge performance measure did not meet the OMHSAS designated performance goal of 10.0%.	<p><u>Follow Up Actions Taken Through 09/30/10</u></p> <p>Development of Drug Screen in IS system July 2010. Piloting of this screen begins September 2010 to assist in appropriate placement of clients. Convened High Utilizer Workgroup (see above) along with data analysis to develop High Utilizer flags in IS system to alert Care Managers to need for special management/referral to Special needs team. June 2010 and ongoing. Developed Dept of Behavioral Health System Metrics to track system performance and implement improvement strategies more quickly. July 2010.</p> <p>Please see Root Cause Analysis for Readmission and Pay-for-Performance (submitted February 1, 2010).</p> <p> Root Cause Analysis Recidivism Write-Up f</p> <p>This item was addressed in the CBH 2009 PEPS Report under Standards 91.10, 91.11 & 91.12 (PEPS pp.80-86). (Also see QM 2010 Work Plan attached.)</p> <p> Appendix 9 Revised 2010 CQI Work Plan.:</p> <hr/> <p><u>Future Actions Planned</u></p> <p>Refine High Utilizer alerts/updates in the IS system and solidify Special Needs Team referral process. December 2010.</p>

Corrective Action Plan

When deficiencies were noted during the PEPS reviews, a Corrective Action Plan response was required from the BH MCO indicating those issues requiring follow-up action. CBH was not required to implement a correct action plan in calendar year 2009.

Root Cause Analysis and Action Plan

The 2010 EQR is the second 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 2009 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. For the 2010 EQR, CBH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures and quality indicators:

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

CBH submitted an initial Root Cause Analysis and Action Plan in June 2010, and a follow-up status update response to IPRO in November 2010.

Table 4.2 Root Cause Analysis for CBH – Follow-up After Hospitalization for Mental Illness HEDIS 7-Day Quality Indicator 1

Performance Measure	
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	
Goal Statement	
Increase HEDIS 7-day follow-up rates by 3% by September 2010.	
Analysis	
<p>Follow-up data was analyzed for a three year period from 2007-2009 to understand and trend post-discharge treatment for all (100%) of discharge episodes (approximately 21,000). Both HEDIS & HEDIS + PA trends were analyzed simultaneously. In addition to follow-up trends, data analysis showed that high rates of follow-up (HEDIS + PA) were positively correlated with high rates of recidivism which was un-expected.</p> <p>For clients with 10 to 17 acute inpatient (AIP) admissions during the analysis period, the next level of care after acute inpatient hospitalization was most frequently rehab, followed by intensive case management (ICM), which deflates HEDIS follow-up rates since 24/7 levels of care and case management are not considered follow-up under HEDIS criteria. For 7-day follow-up, HEDIS measures do not account for intake visits or assessments, which are necessary for referrals to new outpatient providers.</p> <p>When examining follow up rates by primary diagnosis on HEDIS measures, clear strengths and weaknesses emerged. Both 7- and 30-day follow up rates were highest for clients with attention deficit hyper-active disorder/attention deficit disorder (ADHD/ADD) (78% and 89% respectively) and conduct/impulse disorder (55%; 71%). These disorders primarily affect children, an area where CBH does well. Across all providers, our children's recidivism rates are low and follow-up rates are high. Both 7- and 30-day follow up rates were lowest for clients with schizophrenia for HEDIS (29%; 45%) and psychotic disorder not otherwise specified (NOS) (24%; 45%). For HEDIS + PA measures, clear patterns in follow up rates by diagnosis also emerged. Both 7- and 30-day follow up rates were highest for ADHD/ADD (83%; 92%) and conduct/impulse disorder (64%; 79%). Both 7- and 30-day follow up rates were lowest for clients with psychotic disorder NOS (40%; 56%) and mood disorder NOS (43%; 59%).</p> <p>When examining follow up rates by secondary diagnosis on HEDIS measures, 7- and 30-day follow up rates showed similar strengths and weaknesses. Both 7- and 30-day follow up rates were highest for clients with ADHD/ADD (68% and 78% respectively) and conduct/impulse disorder (59%; 77%). Both 7- and 30-day follow up rates were lowest for clients with alcohol abuse (21%; 36%) and drug abuse (26%; 42%). The same secondary diagnosis patterns occurred for HEDIS + PA measures. Seven- and 30-day follow up rates were highest for clients with ADHD/ADD (74%; 85%) and conduct/impulse disorder (63%; 79%). Both 7- and 30-day follow up rates were lowest for clients with alcohol abuse (38%; 53%) and drug abuse (41%; 57%). Analytic findings were previously reported in our QIA and supporting documents; these are attached to this document.</p>	
Policies (e.g., data systems, delivery systems, provider facilities)	<p>1. Root Cause: Need for better discharge planning</p> <p>More consistent use of discharge screens by clinical care managers (e.g., including specific information about the type/level of care, such as drug and alcohol treatment) would facilitate more follow-up reminder calls by CBH Member Services. Utilization of discharge screens would also serve as a prompt for Care Managers to urge inpatient providers to make follow-up appointments and for Care Managers to document those appointments in the system for reporting and analysis.</p>



	<p>Lack of relevant reportable fields in the CBH information system, particularly drug screen results, leads to inappropriate admission to inpatient psychiatric facilities when substance abuse treatment may be warranted.</p>
<p><i>Procedures</i> (e.g., payment/reimbursement, credentialing/collaboration)</p>	<p>2. Root Cause: Inappropriate admission to inpatient psychiatric care for substance abuse clients</p> <p>Inappropriate treatment results in inappropriate follow-up care (i.e., mental health outpatient when the primary problem may be substance abuse) and leaves substance abuse issues unaddressed.</p> <p>Rehab facilities in the CBH provider network frequently do not accept clients for admission on a 24/7 basis, making transfer from Crisis Response Centers difficult.</p>
<p><i>People</i> (e.g., personnel, provider network, patients)</p>	<p>3. Root Cause: Lack of perceived need</p> <p>Timely and successful follow-up requires members to be actively engaged in the linkage process in order to complete the transition to outpatient care. If a member perceived that his/her inpatient stay was an isolated incident or otherwise feels that outpatient care is not necessary, it is unlikely that follow-up care will occur or continue. Nearly 60% of discharges between January 1, 2006 and June 30, 2009 had three or fewer acute inpatient episodes in that time period; members whose daily lives are relatively stable simply may not see the need for additional services. Data analysis showed this subgroup to have the lowest level of follow-up.</p> <p>Clients whose inpatient stays resulted from 302s (i.e., involuntary commitment) may be particularly resistant to follow-up care and may require education and additional engagement strategies. Our regression models showed that these involuntarily committed clients did have fewer inpatient days when connected to drug and alcohol (D&A) treatment (suggesting a high incidence of involvement with substance use/abuse for many of these clients).</p> <p>4. Root Cause: Outpatient wait times</p> <p>It is a standard for routine appointments to occur within 7 days, per our PEPs standards. Outpatient providers overall had an average wait-time of approximately 7 days, but high volume outpatient providers (i.e., greater than 50 referrals in 2009) average was in excess of 7 days. This information is based on data collected from the CBH Member Services database and where the days from the time the appointment was scheduled to the client's appointment were calculated.</p> <p>5. Root Cause: Lack of timely ICM visits</p> <p>Current Department of Behavioral Health (DBH) policy states that ICMs are to see clients within 24 hours of admission to an inpatient facility. If a client presents in a Crisis Response Center (CRC), ICMs are to go to the CRC to see the client and help avert a possibly unnecessary admission. There are no current requirements for ICMs to see clients within a certain timeframe after discharge from an inpatient facility. Routinely, ICMs are expected to make contact with clients every two weeks. Currently ICM visits for those members going to/leaving inpatient are not routinely monitored.</p>
<p><i>Provisions</i> (e.g., screening tools, medical record forms, provider and enrollee educational materials)</p>	<p>6. Root Cause: Inappropriate clinical assessment of clients for substance abuse</p> <p>When presenting clients who screen positive for drugs, a qualitative review revealed that substance abuse issues are often overlooked when they are admitted to inpatient</p>



	psychiatric care. Reports from Appeals Coordinator and discussions with CBH physicians indicated a historical lack of assessment and treatment planning for substance abuse issues.	
<i>Other</i>	N/A	
Action and Monitoring Plan		
Action Plan	Implementation Date	Monitoring Plan
<p><i>Policies</i> Root Cause 1: Need for better discharge planning</p> <p>System enhancements with reportable fields and drop-downs to force choices for completing mandatory discharge fields.</p> <p>Mandatory use of discharge screens</p> <p>Policy development to make AIP providers responsible for scheduling an appointment with ANY physician (medical or psychiatrist) within 30 days of discharge and with an outpatient provider within 7 days of discharge.</p> <p>Policy development for ICMs to receive copy (via fax) of client's discharge plan from AIP provider prior to discharge.</p>	<p>May 2010 and ongoing</p> <p>September 2010</p> <p>June 2010 and ongoing</p> <p>August/September 2010</p> <p>August 2010</p> <p>September/October 2010</p> <p>2011</p> <p>October 2010</p>	<p>Implementation of system reports to show that drug screen results are connected to authorization screens (e.g., not able to complete authorization for 24/7 care without reported drug screen results).</p> <p>Drug Screen function within authorization screen developed for info system. Pending final listing of drugs by CBH Physicians.</p> <p>Implementation of system reports identifying presence/absence of discharge screens on completed episodes of care with Clinical Care Manager information included. Reports to be forwarded to Clinical Management for review and follow-up action with staff.</p> <p>Specifications for reporting on Discharge screens developed. Approval pending.</p> <p>Audit of inpatient charts for evidence of identification of/collaboration with previous outpatient providers and care planning for the 30 days following discharge.</p> <p>Chart audit tools sent to providers. Baseline results due back November 2010.</p> <p>Monitor via development of TCM Provider Profile reports to be completed after re-structuring of Case Management Services in the Philadelphia Dept. of Behavioral Health</p> <p>First draft operational definitions developed. Data validation (CBH and Dept of Behavioral Health Research Info Mgmt) in process as of 11/1/10. For presentation to Targeted Case Mgmt Advisory Group (comprised of DBH staff & providers) 11/2/2010.</p>
<p><i>Procedures</i> 2. Root Cause: Inappropriate admission to inpatient psychiatric care for substance abuse clients</p> <p>Development of Crisis Response Center diversion plan that will result in clients with substance abuse issues being referred directly to substance abuse treatment without first being admitted to inpatient psychiatric treatment.</p>	<p>March 2010</p>	<p>Using [Philadelphia Department of Behavioral Health] (DBH) Research Information Management (RIM) information, track referrals to D&A treatment from the CRCs.</p>



<p>Creation of high-utilizers system alerts that include clients with substance abuse issues to assist care managers in directing clients to most appropriate levels of care.</p>	<p>May 2010 September 2010 October 2010</p>	<p>Use of DBH metrics to determine referral patterns and follow-up patterns for clients. Special Needs Clinical Group configured and staffed to manage high-utilizer population. First group of high utilizers identified and ready for presentation to Special Needs Group within CBH Clinical</p>
<p>Development of "Red-Hot Rehabs" (rehabs who will admit clients directly from Crisis Response Centers even if still intoxicated) underway. This will allow more immediate access for clients who present to Crisis Response Centers under the influence of substances.</p>	<p>January 2010 Oct 2010</p>	<p>Track utilization patterns for clients identified as having high substance abuse needs. Director of Office of Addiction Services met with providers to conceptualize the process. Despite verbal agreement by rehab providers, incidents of refusals to admit continued to occur and require development of protocols to which providers can commit in accepting these clients.</p>
<p>Request for proposal (RFP) for intensive outpatient (IOP) issued to upgrade the quality and engagement of levels of service for drug and alcohol clients following residential D&A treatment.</p>	<p>October 2010</p>	<p>RFP results being analyzed for approval. Monitor number of clients going to IOP as a measure of increased access and engagement.</p>
<p>People 3. Root Cause: Lack of perceived need</p> <p>Development and updating of high-utilizers system alerts in the system that will identify clients with history of 302 commitments as a risk factor.</p> <p>System enhancements to make drug screening results coded/reportable field in CBH information system.</p> <p>4. Root Cause: Outpatient wait times</p> <p>Wait times at most large-volume outpatient agencies exceed 7 days. Develop standard monitoring reports for Member Services to run monthly average wait times beyond 7 days.</p> <p>In many traditional outpatient settings, intakes and assessments precede all other clinical activity. While this is not the only way of gaining access to treatment, it is critical that new clients be seen for at least an assessment/intake within 7 days of discharge; without this appointment, there is little</p>	<p>May 2010 and ongoing November 2010 July 2010 and ongoing July 2010 and ongoing September/October 2010 July 2010 and ongoing</p>	<p>Use of DBH metrics to determine referral patterns and follow-up patterns for clients. Refinement of high-utilizer listing with piloting of cases in Clinical Special Needs unit. (please see above). System monitoring reports for Care Manager documentation. Develop routine "exception" reports for Member Services to run monthly for average wait times beyond 7 days. Specifications for outpatient wait time report (to include routine outpatient appointments and outpatient physician/medication management appointments) developed. Approval pending. Develop routine "exception" reports for discharged members who do not receive an medical doctor visit within 30 days. Note that these reports will also document whether a prior intake occurred within the 7/30 days. This metric will be introduced in 2011 as a provider profile measure for Inpatient Psychiatric discharges.</p>



chance of the client receiving medication management treatment within 30 days.	September/ October 2010	Add medication management follow-up within 30 days to inpatient and outpatient provider profiles in 2011.
Member Services and CQI will develop a self-reporting system for outpatient providers to self-monitor wait times and communicate the monitoring to Member Services on a quarterly basis.	August 2010	Member Services will forward results to CQI for CQI to include in annual PEPs reporting.
Member Services will implement a formalized "secret shopper" program to confirm provider reports		Same as item next above.
5. Root Cause: Lack of timely ICM visits		
Development of "Red-Hot Rehabs" (please see above for description) underway. This will allow more immediate access for clients who present to Crisis Response Centers under the influence of substances.	January 2010	Development of a CRC/Rehab provider policy for referrals and communication about 24/7 acceptance of members and subsequent monitoring report.
<i>Provisions</i> 6. Root Cause: Inappropriate clinical assessment of clients for substance abuse		
Inpatient Provider Profiling Reports to incorporate under chart audit development and implementation in 2010	May 2010 and ongoing	Chart audits to determine whether or not substance abuse issues are part of referral, treatment and aftercare processes.
	November 2010	Baseline chart audits due to CBH for analysis and scoring. Also for discussion at meeting with providers 11/15/2010.
<i>Other (specify)</i>	N/A	N/A

Table 4.3 Root Cause Analysis for CBH – Follow-up After Hospitalization for Mental Illness PA-specific 7 and 30 Day Quality Indicators A and B

Performance Measure
Follow-up After Hospitalization for Mental Illness QI A – PA-specific 7 Day, QI B – PA-specific 30 Day)
Goal Statement
Increase by 4% for 2010 and by an additional 4% for 2011. This is the first year that CBH has implemented Pay-for-Performance with Inpatient, Residential Treatment and D&A Rehab providers. Pay-for-Performance for Targeted Case Management and Outpatient is slated for development and roll-out in 2011.
Analysis
Analysis showed that 12% of all follow-up contacts within 7 days were for ICM services, and an additional 6% of follow-up contacts were for ICMs within 8-30 days of discharge. The goal is for all clients with ICMs to see them within 7 days of discharge. During the reporting period, 2% of clients discharged from inpatient care saw their ICM more than 30 days after discharge which should be corrected by the target of seeing members within 7 days.
Analysis for the 34 outpatient providers within the CBH network who receive more than 50 referrals in 2009 had average wait times (based on 5% trimmed mean) from 28.07 days to 4.88 days. Of those outpatient providers receiving more than 50 referrals in 2009, 27 had wait times in excess of 7 days. Of the 17 outpatient provider agencies receiving more than 100 referrals in 2009, 14 had wait times in excess of 7 days. The remaining three high-volume outpatient providers had wait times of less than 6 days.
Only 6% of all clients discharged are seen for medication management within 30 days of discharge. 2% of discharged clients see



ICMs after 30 days.

Involuntary commitments (i.e., 302s) have been increasing over time. We know that a high percentage of people with a history of 302s have ICMs. For high utilizers (i.e., those with more than 4 AIP admissions) from 2007-2009, 46% have ICMs, and for those with more than 10 AIP admissions, >80% have ICMs.

<p>Policies (e.g., data systems, delivery systems, provider facilities)</p>	<p>1. Root Cause: Lack of timely ICM visits</p> <p>In order to receive ICM services, clients must have demonstrated need (i.e., high utilization of inpatient services within a given year) or history of need. Data analysis showed that for the period of 2006-2009, 45% of clients with 4-9 episodes of acute inpatient treatment and 80% of clients with 10-17 episodes of inpatient treatment during that time period had ICMs assigned. 2% of clients discharged between 1/1/06 and 10/31/09 saw their ICM more than 30 days following discharge. 6% of clients discharged from acute inpatient treatment saw their ICMs between 8 and 30 days post-discharge.</p> <p>Current DBH policy states that ICMs are supposed to see clients within 24 hours of admission to an inpatient facility. If a client presents in a Crisis Response Center, ICMs are supposed to go and see the client and help to avert a possibly unnecessary admission. There are no current requirements for ICMs to see clients within a certain timeframe after discharge from an inpatient facility. Routinely, ICMs are expected to make contact with clients every two weeks.</p> <p>Please see Root Causes #1 above under "HEDIS 7-Day Follow-Up".</p>
<p>Procedures (e.g., payment/reimbursement, credentialing/collaboration)</p>	<p>Please see Root Cause #2 above under "QI 1 - HEDIS 7-Day Follow-Up."</p>
<p>People (e.g., personnel, provider network, patients)</p>	<p>Please see Root Causes #3 through 5 above under "QI 1 - HEDIS 7-Day Follow-Up."</p>
<p>Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)</p>	<p>Please see Root Causes #6 above under "QI 1 - HEDIS 7-Day Follow-Up."</p>
<p>Other</p>	<p>N/A</p>

Action and Monitoring Plan

Action Plan	Implementation Date	Monitoring Plan
<p>Policies</p> <p>1. Root Cause: Clients are not seen in a timely manner by their ICMs when they are hospitalized or after they are discharged</p> <p>Develop policy and communicate expectations that members discharged from AIP have contact with their ICMs within 7 days after discharge.</p> <p>Development of TCM Provider Profile reports to evaluate effectiveness/performance of providers of the various levels of case management services.</p> <p>Develop policy for ICMs to receive faxed copy of discharge plans from AIP providers.</p>	<p>May 2010 and ongoing October/November 2010</p> <p>January 2011</p> <p>September 2011</p>	<p>Development of Monitoring Report.</p> <p>Please see section re: TCM (Targeted Case Management – p. 4-5) report cards above.</p> <p>Creation of ICM Provider Profiles. Please see section re: TCM (Targeted Case Management – p. 4-5) report cards above.</p> <p>Chart audits of AIP providers to determine if fax was sent to ICM. Add to AIP and TCM chart audits due for 2011</p>



Review of high-utilizing clients, identification of risk factors (e.g., co-occurring disorders, presence of serious mental illness, organic brain syndrome, etc.) to determine which clients would most likely benefit from Assertive Community Treatment (ACT), enhanced case management, D&A case management, etc.	March 2011 and ongoing	Develop monitoring reports of impact of TCM teams via ACT or non-ACT case management for high risk members.
<i>Procedures</i>		Refer to response for Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
<i>People</i>		Refer to response for Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
<i>Provisions</i>		Refer to response for Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)
<i>Other (specify)</i>		N/A



V: 2010 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

The review of CBH's 2010 (MY 2009) 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

- Review of compliance with Structure and Operations standards conducted by the Commonwealth in RY 2007, RY 2008, and RY 2009 found CBH to be fully compliant with Subpart C: Enrollee Rights and Protections Regulations.
- CBH submitted one PIP for validation in 2010 and received full credit for all elements reviewed that reflect activities through 2009.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2007, RY 2008, and RY 2009 found CBH to be partially compliant with two Subparts associated with Structure and Operations Standards.
 - CBH was partially compliant on five 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) Coordination and Continuity of Care, 3) Coverage and Authorization of Services, 4) Provider Selection, and 5) Practice Guidelines.
 - CBH 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 and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- CBH's rates for the MY 2009 Follow-up After Hospitalization for Mental Illness HEDIS indicators, QI 1 and QI 2, were statistically significantly lower than the respective MY 2009 HealthChoices BH MCO Averages by 10.5 and 14.3 percentage points respectively.
- CBH's rates for the MY 2009 Follow-up After Hospitalization for Mental Illness PA-specific indicators, QI A and QI B, were statistically significantly lower than the MY 2009 HealthChoices BH MCO Averages by 5.7 and 6.8 percentage points respectively.
- CBH's rate for the MY 2009 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 MCO-specific 2010 (MY 2009) Performance Measure Matrix that follows.



PERFORMANCE MEASURE MATRIX

The Performance Measure (PM) Matrix provides a comparative look quality indicators (QIs) included in the Quality Performance Measures component of the “HealthChoices MCO Pay for Performance Program.” The matrix:

- Compares the BH MCO’s own measure performance over the two most recent reporting years (MY 2009 and MY 2008); and
- Compares the BH MCO’s MY 2009 performance measure rates to the MY 2009 HealthChoices BH MCO Average.

The table 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.

The vertical comparison 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 matrix is color-coded to indicate when the findings for these measures are notable or whether there is cause for action:

-  The green box (A) indicates that performance is notable. The BH MCO’s MY 2009 rate is statistically significantly above the MY 2009 HealthChoices BH MCO Average and trends up from MY 2008.
-  The light green boxes (B) indicate either that the BH MCO’s MY 2009 rate is equal to the MY 2009 HealthChoices BH MCO Average and trends up from MY 2008 or that the BH MCO’s MY 2009 rate is statistically significantly above the MY 2009 HealthChoices BH MCO Average but there is no change from MY 2008.
-  The yellow boxes (C) indicate that the BH MCO’s MY 2009 rate is statistically significantly below the MY 2009 HealthChoices BH MCO Average and trends up from MY 2008 or that the BH MCO’s MY 2009 rate is equal to the MY 2009 HealthChoices BH MCO Average and there is no change from MY 2008 or that the BH MCO’s MY 2009 rate is statistically significantly above the MY 2009 HealthChoices BH MCO Average but trends down from MY 2008. *No action is required although MCOs should identify continued opportunities for improvement.*
-  The orange boxes (D) indicate either that the BH MCO’s MY 2009 rate is statistically significantly below the MY 2009 HealthChoices BH MCO Average and there is no change from MY 2008 or that the BH MCO’s MY 2009 rate is equal to the MY 2009 HealthChoices BH MCO Average and trends down from MY 2008. *A root cause analysis and plan of action is required.*
-  The red box (F) indicates that the BH MCO’s MY 2009 rate is statistically significantly below the MY 2009 HealthChoices BH MCO Average and trends down from MY 2008. *A root cause analysis and plan of action is required.*



COMMUNITY BEHAVIORAL HEALTH (CBH)

KEY POINTS

▪ **A - No CBH performance measure rate fell into this comparison category.**

▪ **B - No CBH performance measure rate fell into this comparison category.**

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

Measure that had no statistically significant change from MY 2008 to MY 2009 and was not statistically significantly different from the MY 2009 HealthChoices BH MCO Average is:

- Readmission within 30 Days of Inpatient Psychiatric Discharge¹

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

Measures that had no statistically significant change from MY 2008 to MY 2009 but were statistically significantly below the MY 2009 HealthChoices BH MCO Averages are:

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

▪ **F - No CBH 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.



Figure 1: Performance Measure Matrix – CBH

		HealthChoices BH MCO Average Statistical Significance Comparison		
Trend		Below / Poorer than Average	Average	Above / Better than Average
Year to Year Statistical Significance Comparison	↑	C	B	A
	No Change	D Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day) Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day) 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)	C Readmission within 30 Days of Inpatient Psychiatric Discharge ²	B
	↓	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.

² Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.



Performance measure rates for MY 2007, MY 2008, and MY 2009 are displayed in Figure 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 2: Performance Measure Rates – CBH

Quality Performance Measure	MY 2007 Rate	MY 2008 Rate	MY 2009 Rate	MY 2009 HC BH MCO Average
Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Day)	33.6%	34.8% =	34.7% =	45.2%
Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Day)	49.4%	51.2% ▲	51.1% =	65.4%
Follow-up After Hospitalization for Mental Illness QI A (PA-Specific 7 Day)	51.6%	52.0% =	52.9% =	58.6%
Follow-up After Hospitalization for Mental Illness QI B (PA-Specific 30 Day)	66.0%	67.4% =	68.0% =	74.8%
Readmission within 30 Days of Inpatient Psychiatric Discharge ³	13.1%	12.8% =	12.9% =	12.3%

³ 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

- CBH was compliant on Subpart C and partially compliant on Subparts D and F. As applicable, compliance review findings from RY 2009, RY 2008, and RY 2007 were used to make the determinations.

Performance Improvement Projects

- CBH submitted one PIP for validation in 2010 and received full credit for all elements reviewed that reflect activities through 2009.

Performance Measures

- CBH reported all performance measures and applicable quality indicators in 2010.

2009 Opportunities for Improvement MCO Response

- CBH provided a response to the opportunities for improvement issued in 2009 and a root cause analysis and action plan for the performance measures noted as performing statistically significantly poorer than the BH MCO average and/or as compared to the prior measurement year.

2010 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for CBH in 2010. The BH MCO will be required to prepare a response for the noted opportunities for improvement in 2011.



APPENDIX

Appendix A: Crosswalk of Required PEPS Items 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. • 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



BBA Category	PEPS Reference	PEPS Language
		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 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



BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§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.	



BBA Category	PEPS Reference	PEPS Language
§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 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



BBA Category	PEPS Reference	PEPS Language
		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.
§438.408 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



BBA Category	PEPS Reference	PEPS Language
		Management Denial Summary Report for the respective review year.
§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



BBA Category	PEPS Reference	PEPS Language
		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.
§438.424 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 Items

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	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



Category	PEPS Reference	PEPS Language
Hearings		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 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.

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