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

2019 External Quality Review Report
Magellan Behavioral Health

FINAL
April 2020

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Table of Contents

List of Tables and Figures

Introduction

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

Overview

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

Objectives

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

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

Report Structure

This technical report includes seven core sections:

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

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

Supplemental Materials

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

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

I: Structure and Operations Standards

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

Organization of the HealthChoices Behavioral Health Program

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

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

Bucks, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual HC BH Contractors. In Calendar Year 2017, Cambria County moved from Beacon Health Organization (BHO) to MBH. If a County is contracted with more than one BH-MCO in the review period, compliance findings for that County are not included in the Structure and Operations section for either BH-MCO for a three-year period.

Table 1.1 shows the name of the HealthChoices Oversight Entity, the associated HealthChoices HC BH Contractor(s), and the county(ies) encompassed by each HC BH Contractor.

Table 1.1: HealthChoices Oversight Entities, HC BH Contractors and Counties

HealthChoices Oversight Entity	HC BH Contractor	County
Bucks County Behavioral Health	Bucks County	Bucks County
Behavioral Health of Cambria County (BHoCC)	Cambria County	Cambria County
Delaware County – DelCare Program	Delaware County	Delaware County
Lehigh County HealthChoices	Lehigh County	Lehigh County
Montgomery County Behavioral Health	Montgomery County	Montgomery County
Northampton County HealthChoices	Northampton County	Northampton County

HC: HealthChoices; BH: behavioral health.

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 MBH by OMHSAS monitoring staff within the past three review years (RYs 2018, 2017, and 2016). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2018. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within

the three-year time frame under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

Data Sources

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

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

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

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

Because OMHSAS's review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The three-year period is alternatively referred to as the Active Review period. The PEPS Substandards from RY 2018, RY 2017, and RY 2016 provided the information necessary for the 2018 assessment. Those triennial standards not reviewed through the PEPS system in RY 2018 were evaluated on their performance based on RY 2017 and/or RY 2016 determinations, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year

time frame under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

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

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for MBH

Table 1.2 tallies the PEPs Substandard reviews used to evaluate the HealthChoices Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2016–2018). Substandard counts under RY 2018 include both annual and triennial substandards; Substandard counts under RYs 2017 and 2016 comprise only triennial substandards. By definition, only the last review of annual substandards is counted in the three-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 1.2,** 175, differs from the unique count of substandards that came under active review (79).

Table 1.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for MBH

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

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
Recordkeeping and Recording Requirements	0	0	0	0	0
Continuation of Benefits Pending Appeal & State Fair Hearings	6	0	2	0	4
Effectuation of Reversed Resolutions	6	0	2	0	4
Total	175	1	75	28	71

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

[2] The number of sub-standards that came under active review during the cycle specific to the review year. Because sub-standards may cross-walk to more than one category, the total tally of sub-standard reviews (175) differs from the unique count of sub-standards that came under active review (79).

BBA: Balanced Budget Act; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: Sub-standards not reviewed; RY: review year; NR: sub-standards not reviewed; N/A: category not applicable.

For RY 2018, nine of the above categories – 1) Provider-Enrollee Communications, 2) Marketing Activities, 3) Liability for Payment, 4) Cost Sharing, 5) Emergency and Post-Stabilization Services, 6) Solvency Standards, 7) Elements of State Quality Strategies, 8) Confidentiality, and 9) Recordkeeping and Recording Requirements – were not directly addressed by the PEPS Substandards reviewed. As per OMHSAS's judgment, seven of the nine categories not covered directly by PEPS are covered in the HealthChoices Behavioral Health Program's PS&R. Information pertaining to Marketing Activities is not addressed in any of the documents provided because the category is considered Not Applicable for the BH-MCOs. The category of Marketing Activities is Not Applicable because, as a result of the Centers for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per county. Compliance for the Cost Sharing category is not assessed by PEPS Substandards, as any cost sharing imposed on Medicaid enrollees is in accordance with CMS regulation 42 CFR 447.50–447.60.

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

Determination of Compliance

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

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in *CMS EQR Protocol #1: Assessment of Compliance with*

Medicaid Managed Care Regulations ("Quality of Care External Quality Review," 2012)[1]. Under each general subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under Enrollee Rights and Protections, Quality Assessment and Performance Improvement (including access, structure and operation, and measurement and improvement standards), and Federal and State Grievance System Standards.

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

Findings

Seventy-nine unique PEPS Substandards were used to evaluate MBH and its Oversight Entities compliance with BBA regulations in RY 2018.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this subpart is to ensure that each HC BH Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the HC BH Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees (42 CFR 438.100 [a], [b]). **Table 1.3** presents the findings by categories.

Table 1.3: Compliance with Enrollee Rights and Protections Regulations

Subpart C: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Enrollee Rights 438.100	Partial	None	All MBH HC BH Contractors	14 substandards were crosswalked to this category. Delaware, Lehigh, Montgomery, and Northampton were evaluated on 14 substandards, compliant with 12 substandards, and non-compliant with 2 substandards. The Bucks HC BH Contractor was evaluated on 14 substandards, compliant with 11 substandards, and non-compliant with 3 substandards.
Provider-Enrollee Communications 438.102	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections II-5 F.7 and section II-4 A.5.a.
Marketing Activities 438.104	N/A	N/A	N/A	Not applicable due to CMS HealthChoices waiver. Consumers are assigned to BH-MCOs based on their county of residence.
Liability for Payment 438.106	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections II-7 A.5.a and A.9-A.10.
Cost Sharing 438.108	Compliant	All MBH HC BH Contractors		Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50–447.60.
Emergency and Post-Stabilization Services 438.114	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections II-4 A.4, B.6 and C.2.

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

Subpart C:	MCO	By HC BH Contractor		Comments
Solvency Standards 438.116	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections II-7 A and the 2018–2019 Solvency Requirements tracking reports.

MCO: managed care organization; HC: HealthChoices; BH: behavioral health; MBH: Magellan Behavioral Health; PS&R: Program Standards and Requirements; N/A: not applicable; CFR: Code of Federal Regulations; N/A: not applicable.

There are 7 categories within Subpart C Enrollee Rights and Protections. MBH was compliant with 5 categories and partially compliant with 1 category. The remaining category was considered not applicable as OMHSAS received a CMS waiver on the Marketing Activities category. Of the 5 compliant categories, 4 were compliant as per the HealthChoices PS&R and 1 category was compliant as per CMS Regulation 42 CFR 447.50–447.60. The remaining category, Solvency Standards, was compliant based on the 2018–2019 Solvency Requirement tracking reports and the HealthChoices PS&R.

Of the 14 PEPS substandards that were crosswalked to the category of Enrollee Rights, all 14 were evaluated for each HC BH contractor. Delaware, Lehigh, Montgomery, and Northampton were evaluated on 14 substandards, compliant with 12 substandards, and non-compliant with 2 substandards. The Bucks HC BH Contractor was evaluated on 14 substandards, compliant with 11 substandards, and non-compliant with 2 substandards.

Enrollee Rights

All HC BH Contractors associated with MBH were partially compliant with Enrollee Rights due to non-compliance with substandards of PEPS Standard 60 (RY 2016) and 108 (RY 2017).

PEPS Standard 60:

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

All MBH HC BH Contractors were non-compliant with Substandards 2 and 3 of PEPS Standard 60 (RY 2016).

> **Substandard 2:** Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances.
>
> **Substandard 3:** The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H.

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

One MBH HC BH Contractors, Bucks County, was non-compliant with Substandard 1 of PEPS Standard 108 (RY 2017).

Substandard 1: County/BH-MCO oversight of C/FST Program ensures HC contractual requirements are met.

Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid managed care program, the HealthChoices Program, are available and accessible to MCO enrollees [42 CFR 438.206 (a)]. The PEPS documents for each HC BH Contractor include an assessment of the HC BH Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: Compliance with Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Elements of State Quality Strategies 438.204	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections II-5 G and II-6 A and B.3.
Availability of Services (Access to Care) 438.206	Partial		All MBH HC BH Contractors	24 substandards were crosswalked to this category. Bucks, Delaware, and Montgomery were evaluated on 23 substandards, compliant with 21 substandards, and non-compliant with 2 substandards. The Lehigh and Northampton HC BH Contractors were evaluated on 23 substandards, compliant with 20 substandards and non-compliant with 3 substandards.
Coordination and Continuity of Care 438.208	Non-compliant			2 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 2 substandards and was non-compliant on 2 substandards.
Coverage and Authorization of Services 438.210	Partial		All MBH HC BH Contractors	4 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 4 substandards, was compliant on 1 substandard, partially compliant on 1 substandard, and was non-compliant on 2 substandards.
Provider Selection 438.214	Compliant	All MBH HC BH Contractors		3 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 3 substandards and was compliant on 3 substandards.
Confidentiality 438.224	Compliant	All MBH HC BH Contractors		Compliant as per PS&R sections II-4 B, C.6, D.3, and G.4, II-6 B.3, II-7 K.4
Subcontractual Relationships and Delegation 438.230	Compliant	All MBH HC BH Contractors		8 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 8 substandards and was compliant on 8 substandards.
Practice Guidelines 438.236	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, was compliant on 4 substandards, and was non-compliant on 2 substandards.
Quality Assessment and Performance Improvement Program 438.240	Partial		All MBH HC BH Contractors	26 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 26 substandards, was compliant on 21 substandards, partially compliant on 4 substandards, and non-compliant on 1 substandard.
Health Information Systems 438.242	Compliant	All MBH HC BH Contractors		1 substandard was crosswalked to this category. Each HC BH Contractor was evaluated on 1 substandard and was compliant on this substandard.

MCO: managed care organization; HC: HealthChoices; BH: behavioral health; MBH: Magellan Behavioral Health; PS&R: Program Standards and Requirements.

Of the 10 Quality Assessment and Performance Improvement Regulations categories, MBH was compliant with 5 categories, partially compliant with 4 categories, and non-compliant with 1 category. Two (2) of the five categories with which MBH was compliant– Elements of State Quality Strategies and Confidentiality – were not directly addressed by any PEPS items, but were determined to be compliant as per the HealthChoices PS&R.

For this review, 74 substandards were crosswalked to Quality Assessment and Performance Improvement Regulations. Each HC BH Contractor was evaluated on 73 substandards. There was 1 substandard not scheduled or not applicable for evaluation for RY 2018. Bucks, Delaware, and Montgomery were compliant with 59 substandards, partially compliant with 5 substandards, and non-compliant with 9 substandards. Lehigh and Northampton were compliant with 58 substandards, partially compliant with 5 substandards, and non-compliant with 10 substandards. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA categories with partially compliant or non-compliant ratings.

Availability of Services (Access to Care)

All HC BH Contractors associated with MBH were partially compliant with Availability of Services (Access to Care) due to non-compliance with two substandards of PEPS Standard 28 and one substandard of PEPS Standard 1.

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

All MBH HC BH Contractors were non-compliant with Substandards 1and 2 of PEPS Standard 28 (RY 2016).

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

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

Lehigh and Northampton MBH HC BH Contractors were non-compliant with Substandard 2 of PEPS Standard 1 (RY 2017).

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

Coordination and Continuity of Care

All HC BH Contractors associated with MBH were non-compliant with Coordination and Continuity of Care due to non-compliance with two substandards of PEPS Standard 28. All MBH HC BH Contractors were non-compliant with Substandard 1 and 2 of PEPS Standard 28 (RY 2016).

PEPS Standard 28: See Standard and non-compliant Substandard descriptions under Availability of Services (Access to Care). All MBH HC BH Contractors were non-compliant with Substandard 1 and 2 of PEPS Standard 28 (RY 2016).

Coverage and Authorization of Services

All HC BH Contractors associated with MBH were partially compliant with Coverage and Authorization of Services due to non-compliance with two substandards of PEPS Standard 28 (RY 2016) and partial compliance with one substandard of PEPS Standard 72 (RY 2018).

PEPS Standard 28: See Standard and non-compliant Substandard descriptions under Availability of Services (Access to Care). All MBH HC BH Contractors were non-compliant with Substandard 1,and 2 of PEPS Standard 28 (RY 2016).

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

All MBH BH Contractors were partially compliant with Substandard 2 of PEPS Standard 72 (RY 2018)

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

Practice Guidelines

All HC BH Contractors associated with MBH were partially compliant with Practice Guidelines due to non-compliance with two substandards of PEPS Standard 28 (RY 2016).

PEPS Standard 28: See Standard and non-compliant Substandard descriptions under Availability of Services (Access to Care). All MBH HC BH Contractors were non-compliant with Substandard 1 and 2 of PEPS Standard 28 (RY 2016).

Quality Assessment and Performance Improvement MCO Status

All HC BH Contractors associated with MBH were partially compliant with Quality Assessment and Performance Improvement MCO Status due to non-compliance with one substandard and partial-compliance with four substandards of PEPS Standard 91 (RY 2018).

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

All MBH HC BH Contractors were partially compliant with Substandards 5, 6, 10, and 11 of PEPS Standard 91 (RY 2018).

Substandard 5: The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).

Substandard 6: The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.

Substandard 10: The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.

Substandard 11: The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
All MBH HC BH Contractors were non-compliant with Substandard 14 of PEPS Standard 91 (RY 2018).

All MBH HC BH Contractors were non-compliant with Substandard 14 of PEPS Standard 91 (RY 2018).

Substandard 14: The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the annual evaluation and any corrective actions required from previous reviews.

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the HC BH Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 1.5** presents the findings by categories consistent with the regulations.

Table 1.5: Compliance with Federal and State Grievance System Standards

Subpart F: Categories	MCO Compliance Status	By HC BH Contractor		Comments
		Fully Compliant	Partially Compliant	
Statutory Basis and Definitions 438.400	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 2 substandards, partially compliant on 4 substandards, and non-compliant on 5 substandards.
General Requirements 438.402	Partial		All MBH HC BH Contractors	14 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 14 substandards, compliant on 3 substandards, partially compliant on 4 substandards, and non-compliant on 7 substandards.
Notice of Action 438.404	Partial		All MBH HC BH Contractors	13 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 13 substandards, compliant on 12 substandards, and partially compliant on 1 substandard.
Handling of Grievances and Appeals 438.406	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 2 substandards, partially compliant on 4 substandard, and non-compliant on 5 substandards.
Resolution and Notification: Grievances and Appeals 438.408	Partial		All MBH HC BH Contractors	11 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 11 substandards, compliant on 2 substandard, partially compliant on 4 substandard, and non-compliant on 5 substandards.
Expedited Appeals Process 438.410	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 2 substandard, partially compliant on 3 substandards, and non-compliant on 1 substandard.
Information to Providers & Subcontractors 438.414	Partial		All MBH HC BH Contractors	9 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 9 substandards compliant on 1 substandard, partially compliant on 3 substandards, and non-compliant on 5 substandards..
Recordkeeping and Recording Requirements 438.416	Compliant	All MBH HC BH Contractors		Compliant as per the required quarterly reporting of complaint and grievances data.
Continuation of Benefits 438.420	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 2 substandards, partially compliant on 3 substandards, and non-compliant on 1 substandards.
Effectuation of Reversed Resolutions 438.424	Partial		All MBH HC BH Contractors	6 substandards were crosswalked to this category. Each HC BH Contractor was evaluated on 6 substandards, compliant on 2 substandards, partially compliant on 3 substandards, and non-compliant on 1 substandards.

MCO: managed care organization; HC: HealthChoices; BH: behavioral health; MBH: Magellan Behavioral Health.

MBH was evaluated for compliance with the 10 categories of Federal and State Grievance System Standards. MBH was compliant with 1 category and partially compliant with 9 categories. The category of Recordkeeping and Recording Requirements was compliant per the quarterly reporting of complaint and grievances data. Each MBH HC BH Contractor was compliant with 1 category and partially compliant with 9 categories.

For this review, 87 substandards were crosswalked to this Subpart for all five MBH HC BH Contractors, and each HC BH Contractor was evaluated on 87 substandards. The five HC BH Contractors were compliant with 28 substandards, partially compliant with 29 substandards, and non-compliant with 30 substandards. As previously stated, some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA categories with partially compliant or non-compliant ratings.

The five MBH HC BH Contractors that were evaluated were partially compliant with 9 of the 10 categories pertaining to Federal and State and Grievance System Standards due to non-compliance with substandards within PEPS Standards 60, 68, and 71, and partial compliance with substandards within PEPS Standard 68, 71, and 72.

Statutory Basis and Definitions

All HC BH Contractors associated with MBH were partially compliant with Statutory Basis and Definitions due to non-compliance with four substandards of PEPS Standard 68 and two substandards of PEPS Standard 71, and partial compliance with one substandard of PEPS Standard 68, one substandard of PEPS Standard 71, and one substandard of PEPS Standard 72.

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

All MBH HC BH Contractors were partially compliant with one substandard (Substandard 1) and non-compliant with four substandards (Substandards 3, 4, and 9) of Standard 68 (RY 2016).

Substandard 1: Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how the compliant rights and procedures are made known to members, BH-MCO staff, and the provider network: 1. 1st level, 2. 2nd level, 3. External, 4.Expedited, 5.Fair Hearing.

Substandard 3: 100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

Substandard 4: Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).

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

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

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

All MBH HC BH Contractors were partially compliant with two substandards (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

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: 1. Internal, 2. External, 3. Expedited, 4. Fair Hearing.

Substandard 3: 100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

Substandard 4: Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

General Requirements

All HC BH Contractors associated with MBH were partially compliant with General Requirements due to both non-compliance and partial compliance of substandards of PEPS Standards 60, 68, 71, and 72.

PEPS Standard 60: See Standard description and determination of compliance under Enrollee Rights. All MBH HC BH Contractors were non-compliant with Substandards 2 and 3 of PEPS Standard 60 (RY 2016).

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with one substandard (Substandard 1) and non-compliant with four substandards of Standard 68 (RY 2016).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with two substandard (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

Notice of Action

All HC BH Contractors associated with MBH were partially compliant with Notice of Action due to partial compliance with one substandard of PEPS Standard 72 (RY 2018).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

Handling of Grievances and Appeals

All HC BH Contractors associated with MBH were partially compliant with Handling of Grievances and Appeals due to non-compliance and partial compliance with substandards of PEPS Standards 68, 71, and 72.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with one substandard (Substandard 1) and non-compliant with four substandards of Standard 68 (RY 2016).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definition. All MBH HC BH Contractors were partially compliant with two substandards (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

Resolution and Notification: Grievances and Appeals

All HC BH Contractors associated with MBH were partially compliant with Resolution and Notification: Grievances and Appeals due to non-compliance and partial compliance with substandards of PEPS Standards 68, 71, and 72.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with one substandard (Substandard 1) and non-compliant with four substandards) of Standard 68 (RY 2016).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with two substandards (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

Expedited Appeals Process

All HC BH Contractors associated with MBH were partially compliant with Expedited Appeals Process due to partial or non-compliance with substandards of PEPS Standard 71 and 72.

PEPS Standard 71: See Standard and description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with two substandards (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

Information to Providers & Subcontractors

All HC BH Contractors associated with MBH were partially compliant with Information to Providers and Subcontractors due to partial compliance and non-compliance with Substandards of PEPS Standards 68 and 71.

PEPS Standard 68: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with one substandard (Substandard 1) and non-compliant with four substandards of Standard 68 (RY 2016).

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with two substandards (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

Continuation of Benefits

All HC BH Contractors associated with MBH were partially compliant with Continuation of Benefits due to partial or non-compliance with substandards of PEPS Standard 71 and 72.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with two substandards (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

Effectuation of Reversed Resolutions

All HC BH Contractors associated with MBH were partially compliant with Effectuation of Reversed Resolutions due to partial or non-compliance with substandards of PEPS Standard 71.

PEPS Standard 71: See Standard description and determination of compliance under Statutory Basis and Definitions. All MBH HC BH Contractors were partially compliant with two substandards (Substandards 1 and 4) and non-compliant with one substandard (Substandard 3) of Standard 71 (RY 2016).

PEPS Standard 72: See Standard description and determination of compliance under Coverage and Authorization of Services. All MBH HC BH Contractors were partially compliant with substandard 2 of PEPS Standard 72 (RY 2018).

II: Performance Improvement Projects

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

Background

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

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

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

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

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

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

additional interim report in 2018, as well as a final report in 2019. MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a collaboration between the HC BH Contractors and MCOs. The MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contractor-level data and illustrate how HC BH Contractor knowledge of their high-risk populations contributes to addressing the barriers within their specific service areas. Each MCO will submit the single root-cause/barrier analysis according to the PIP schedule. This PIP was formally introduced to the MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4, 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the MCOs and HC BH Contractors, as needed.

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

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

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

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

Validation Methodology

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

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

The first 9 elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial, and non-compliance. As calendar year 2018 was the final intervention year for all MCOs, IPRO reviewed all 10 elements, including sustained improvement, for each MCO.

Review Element Designation/Weighting

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

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

Table 2.1: Review Element Scoring Designations and Definitions

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

Overall Project Performance Score

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

Table 2.2: Review Element Scoring Weights

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

Scoring Matrix

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

Findings

MCO submitted their Year 3 PIP Update document for review in August 2018. IPRO provided feedback and comments to MCO on this submission. **Table 2.3** presents the PIP scoring matrix for this August 2018 Submission, which corresponds to the key findings of the review described in the following paragraphs. MBH received a total demonstrable improvement score of 67.5 out of 80 points (84.4%) and a sustained improvement score of 20 out of 20 points (100%) for an overall project performance score of 80 of 100 (80%). MBH's overall compliance with the PIP requirements was therefore a Partial Met.

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

Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 – Project Topic and Relevance	M	100	5%	5
Review Element 2 – Study Question (AIM Statement)	M	100	5%	5
Review Element 3 – Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 – Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 – Data Collection Procedures	M	100	10%	10
Review Element 7 – Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 – Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**70**
Review Element 10 – Sustainability of Documented Improvement	PM	50	20%	10
TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**10**
OVERALL PROJECT PERFORMANCE SCORE			**100%**	**80**

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

As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The MCO was fully compliant with review element(s) 1 thru 7, corresponding to the project topic, study design, variables, population, sampling and data collection and interventions' sections.

However, IPRO noted deficiencies with regards to elements 8 and 9 relating to the interpretation of study results and validity of reported improvement. Although IPRO found that the BH-MCO provided visual graphics and tables in the narrative that enhanced data interpretation, and presented a comprehensive data analysis plan for each measure, it should have dedicated more discussion to possible factors which may have led to failed implementation or lack of improvement in the performance measure. Moreover, MBH only included statistical significance testing for MY 2016 and MY 2017, while it would have been helpful to compare rates for baseline (MY 2014), Year 1 (MY 2015), Year 2 (MY 2016), Year 3 (2017), and Year 4 of performance indicator results. The BH-MCO should also have included a comparison of year-over-year rates for key subpopulations. It would have been helpful to investigate if an intervention that does not work for the overall population works or does not work for a certain sub-population. IPRO recommends, for example, comparing county rates.

The BH-MCO reported limitations and barriers to data collection and validation, as well as complicating factors. The plan should expand on these topics in future PIP studies and clarify how they can impact the interpretation (e.g. confounders and details on threats to validity of results). MBH provided detailed information about process measures and core outcome measures for the targeted population. The Plan included details of barriers each intervention was facing which improved clarity and consistency of PIP reporting. Barriers to implementation, follow-up activities, and next steps are also discussed under this section. The BH-MCO explained and interpreted the results based on validated information with precise and clear reporting techniques. Success or failure of individual PIP components and rationale for follow-up activities were reported and could be clearly linked to the findings. The MCO is encouraged to continue to test such hypotheses beyond the life of this particular PIP. Moreover, although the BH-MCO performed statistical testing to provide evidence whether the observed improvement represented a statistically significant difference, the analysis and discussion leaves unclear the face validity of any reported improvements, i.e., whether they have been responsible in improving performance.

With regard to sustainability of reported improvement IPRO found the BH-MCO successfully documented barriers to the analysis and interventions. However, the fact that providers dropped out mid-stream from the various interventions probably at least partly explains why interventions did not result in statistically significant sustained improvement in the performance indicators. That is, overall, the MCO did not evidence significant improvement in the BHR and SAA indicators over the course of the PIP (and in fact the BHR-SA rate significantly increased). DMP change was mixed across the numerators. No p-value was calculable for DMP since samples were drawn at the facility-level and therefore not generalizable at the BH-MCO level. The MCO opted not to do a DMP re-measurement in 2018.

III: Performance Measures

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

Follow-up After Hospitalization for Mental Illness

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

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

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

Measure Selection and Description

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

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

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

Eligible Population

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

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2018;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

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

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

HEDIS Follow-up Indicators

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

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

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

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

PA-Specific Follow-up Indicators

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

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

Quality Indicator B (QI B): Follow-up After Hospitalization for Mental Illness Within 30 Days after Discharge (Calculation based on Numerator 1 codes and additional PA-specific codes not used in HEDIS)
Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator Significance

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

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

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

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

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

Methodology

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

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2018 (MY 2017), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years) measure. OMHSAS established a 3-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more prospective and proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 BBA report. Due to this change in the goal-setting method, no goals were set for MY 2018.

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

Data Analysis

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

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

Where:

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

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

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

Where:

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

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

$$H_0: p1 = p2$$

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

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

Limitations

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

Findings

BH-MCO and HC BH Contractor Results

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

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

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

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

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

I: HEDIS Follow-up Indicators

(a) Age Group: 18–64 Years Old

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

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

MY 2018							MY 2018 Rate Comparison	
				95% CI		MY 2017	To MY 2017	
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI1 – HEDIS 7-Day Follow-up (18–64 Years)								
HealthChoices (Statewide)	11347	31939	**35.5%**	35.0%	36.1%	35.3%	0.3	NO
Magellan	1946	5571	**34.9%**	33.7%	36.2%	32.2%	2.7	YES
Bucks	337	978	**34.5%**	31.4%	37.5%	30.3%	4.1	NO
Cambria	156	489	**31.9%**	27.7%	36.1%	30.0%	1.9	NO
Delaware	302	983	**30.7%**	27.8%	33.7%	31.2%	-0.5	NO
Lehigh	453	1208	**37.5%**	34.7%	40.3%	32.8%	4.7	YES
Montgomery	449	1200	**37.4%**	34.6%	40.2%	34.3%	3.1	NO
Northampton	249	713	**34.9%**	31.4%	38.5%	31.9%	3.1	NO
QI2 – HEDIS 30-Day Follow-up (18–64 Years)								
HealthChoices (Statewide)	17896	31939	**56.0%**	55.5%	56.6%	56.3%	-0.3	NO
Magellan	3205	5571	**57.5%**	56.2%	58.8%	54.1%	3.4	YES
Bucks	552	978	**56.4%**	53.3%	59.6%	50.2%	6.2	YES
Cambria	283	489	**57.9%**	53.4%	62.4%	62.5%	-4.6	NO
Delaware	490	983	**49.8%**	46.7%	53.0%	48.9%	0.9	NO
Lehigh	735	1208	**60.8%**	58.1%	63.6%	56.3%	4.5	YES
Montgomery	719	1200	**59.9%**	57.1%	62.7%	56.3%	3.6	NO
Northampton	426	713	**59.7%**	56.1%	63.4%	56.9%	2.9	NO

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

The MY 2018 HealthChoices Aggregate (Statewide) HEDIS follow-up rates in the 18 to 64 years age group were 35.5% for QI 1 and 56.0% for QI 2 (**Table 3.1**). These rates were not statistically significantly lower than the HealthChoices Aggregate rates for this age group in MY 2017, which were 35.3% and 56.3%, respectively. The MY 2018 MBH QI 1 rate for members ages 18 to 64 years was 34.9%, compared to 32.2% in MY 2017 (**Table 3.1**). The corresponding QI 2 rate was 57.5%, a 3.4 percentage point increase from the MY 2017 rate of 54.1%. Both the QI 1 and QI 2 rates were statistically significantly higher compared to MY 2017.

From MY 2017 to MY 2018, Lehigh was the only HC BH Contractor that showed a statistically significant change in the QI 1 rate from 32.8% to 37.5%, a 4.7 percentage point increase (**Table 3.1**). For QI 2, Bucks and Lehigh had rates of 56.4% in Bucks and 60.8% in Lehigh for MY 2018 compared to 50.2% and 56.3%, a 6.2 percentage point and 4.5 percentage point increase from the prior year.

Figure 3.1 is a graphical representation of MY 2018 HEDIS FUH 7- and 30-Day follow-up rates in the 18 to 64 years old population for MBH and its associated HC BH Contractors. The orange line indicates the MCO average.

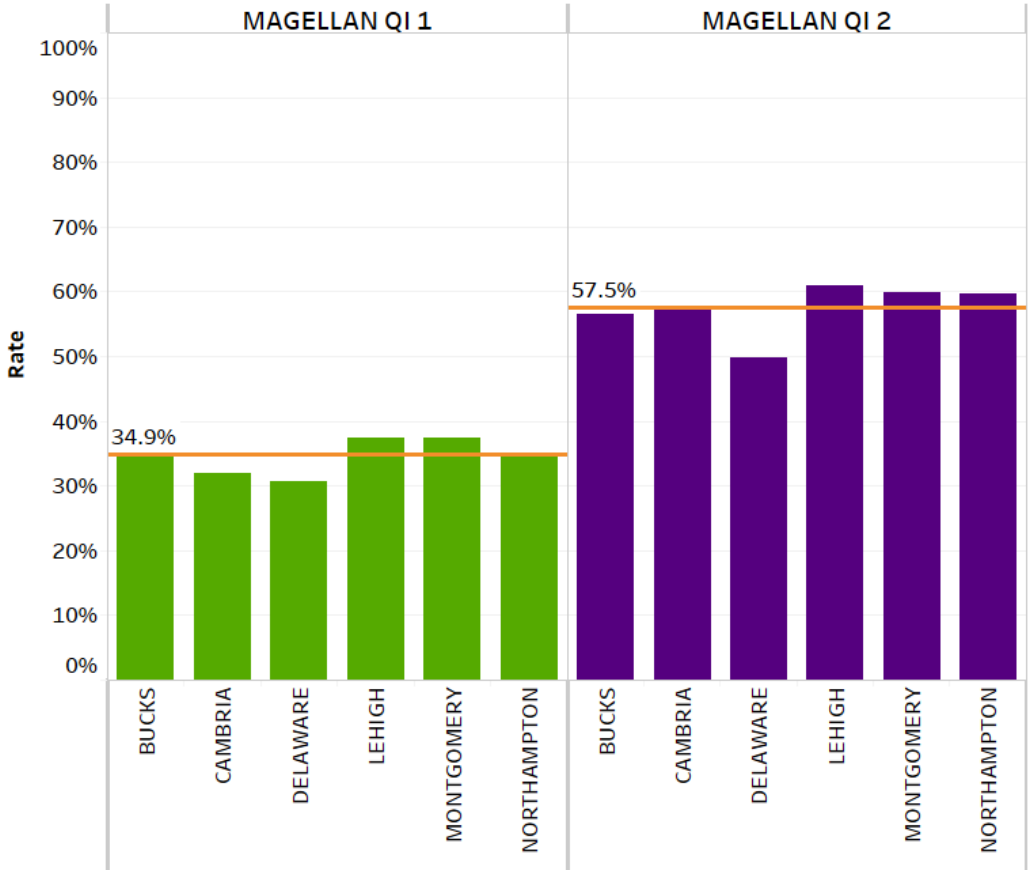

Figure 3.1: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (18–64 Years).

Figure 3.2 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the HC BH (Statewide) rate. The QI 1 rate for Delaware was statistically significantly below the MY 2018 QI 1 HC BH rate of 35.5% by 4.8 percentage points. The QI 2 rates for Lehigh and Montgomery were statistically significantly above the QI 2 HC BH rate of 56.0% by 4.8 and 3.9 percentage points, respectively.

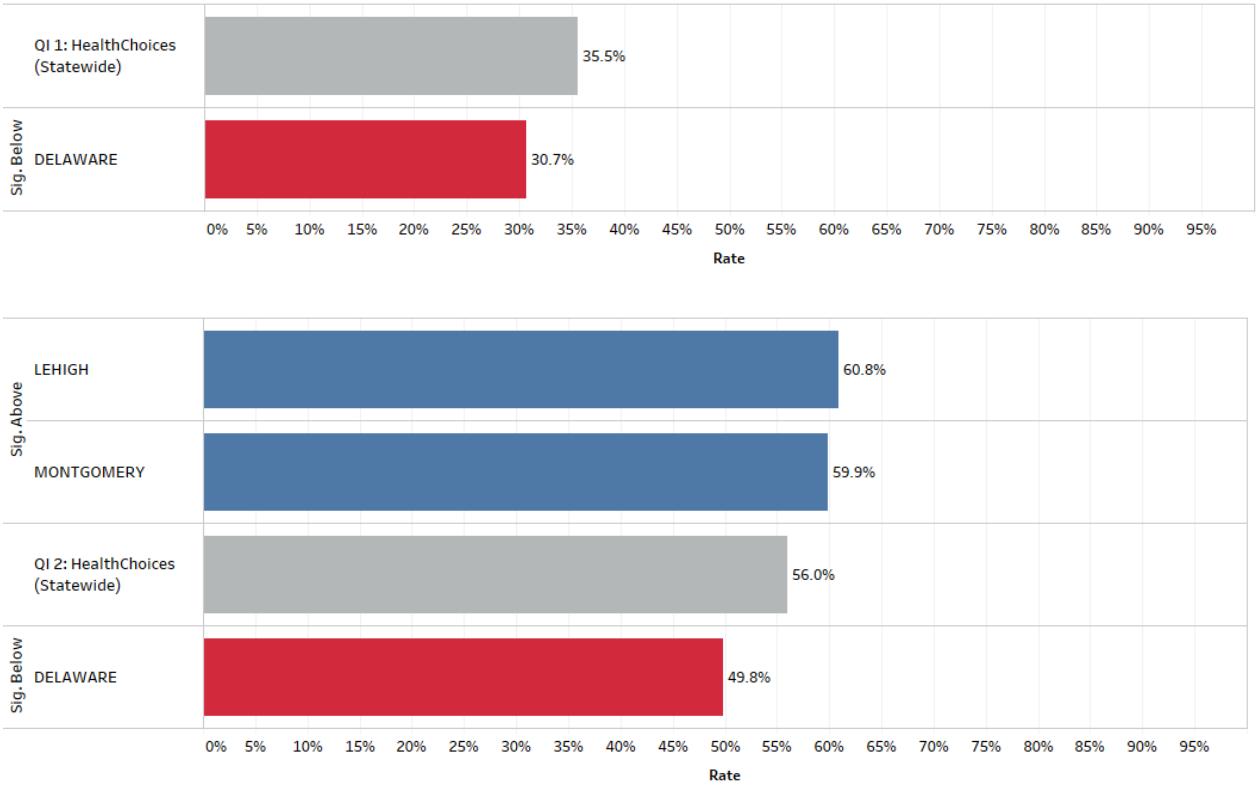

Figure 3.2: MBH Contractor MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (18–64 Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (6–64 Years).

(b) Overall Population: 6+ Years Old

The MY 2018 HealthChoices Aggregate HEDIS follow-up rates were 39.4% for QI 1 and 60.2% for QI 2 (**Table 3.2**). These rates were not statistically significantly lower than the HealthChoices Aggregate rates in MY 2017. For MBH, the MY 2018 QI 1 rate was 37.3%, a statistically significant increase of 2.2 percentage points from the prior year. The MBH QI 2 rate was 60.3%, a statistically significant increase of 2.8 percentage points from the MY 2017 QI 2 rate. Lehigh experienced a statistically significant increase of 4.3 percentage points up from 35.1% in MY 2017; all other contractors did not experience a statistically significant change for QI 1. For QI 2, Bucks and Lehigh both experienced a statistically significant increase compared to MY 2017 (**Table 3.2**).

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

MY 2018							MY 2018 Rate Comparison		To HEDIS 2019 Percentiles
				95% CI		MY	To MY 2017		
Measure	(N)	(D)	%	Lower	Upper	2017 %	PPD	SSD	
QI1 – HEDIS 7-Day Follow-up (All Ages									
HealthChoices (Statewide)	16107	40876	39.4%	38.9%	39.9%	39.1%	0.3	NO	Below 75th Percentile, Above 50th Percentile
Magellan	2644	7088	37.3%	36.2%	38.4%	35.1%	2.2	YES	Below 75th Percentile, Above 50th Percentile
Bucks	453	1222	37.1%	34.3%	39.8%	33.2%	3.9	NO	Below 75th Percentile, Above 50th Percentile
Cambria	200	605	33.1%	29.2%	36.9%	33.6%	-0.5	NO	Below 50th Percentile, Above 25th Percentile
Delaware	435	1252	34.7%	32.1%	37.4%	34.0%	0.7	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	596	1513	39.4%	36.9%	41.9%	35.1%	4.3	YES	Below 75th Percentile, Above 50th Percentile
Montgomery	606	1521	39.8%	37.3%	42.3%	38.0%	1.9	NO	Below 75th Percentile, Above 50th Percentile
Northampton	354	975	36.3%	33.2%	39.4%	34.3%	2.0	NO	Below 75th Percentile, Above 50th Percentile
QI2 – HEDIS 30-Day Follow-up (All Ages)									
HealthChoices (Statewide)	24587	40876	60.2%	59.7%	60.6%	60.6%	-0.5	NO	Below 75th Percentile, Above 50th Percentile
Magellan	4274	7088	60.3%	59.2%	61.4%	57.5%	2.8	YES	Below 75th Percentile, Above 50th Percentile
Bucks	735	1222	60.1%	57.4%	62.9%	54.5%	5.6	YES	Below 75th Percentile, Above 50th Percentile
Cambria	365	605	60.3%	56.3%	64.3%	65.3%	-4.9	NO	Below 75th Percentile, Above 50th

MY 2018							MY 2018 Rate Comparison		To HEDIS 2019 Percentiles
									Percentile
Delaware	674	1252	53.8%	51.0%	56.6%	53.1%	0.7	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	951	1513	62.9%	60.4%	65.3%	59.1%	3.7	YES	Below 75th Percentile, Above 50th Percentile
Montgomery	950	1521	62.5%	60.0%	64.9%	59.5%	2.9	NO	Below 75th Percentile, Above 50th Percentile
Northampton	599	975	61.4%	58.3%	64.5%	59.5%	1.9	NO	Below 75th Percentile, Above 50th Percentile

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

Figure 3.3 is a graphical representation of the MY 2018 HEDIS follow-up rates for MBH and its associated HC BH Contractors. The orange line indicates the MCO average.

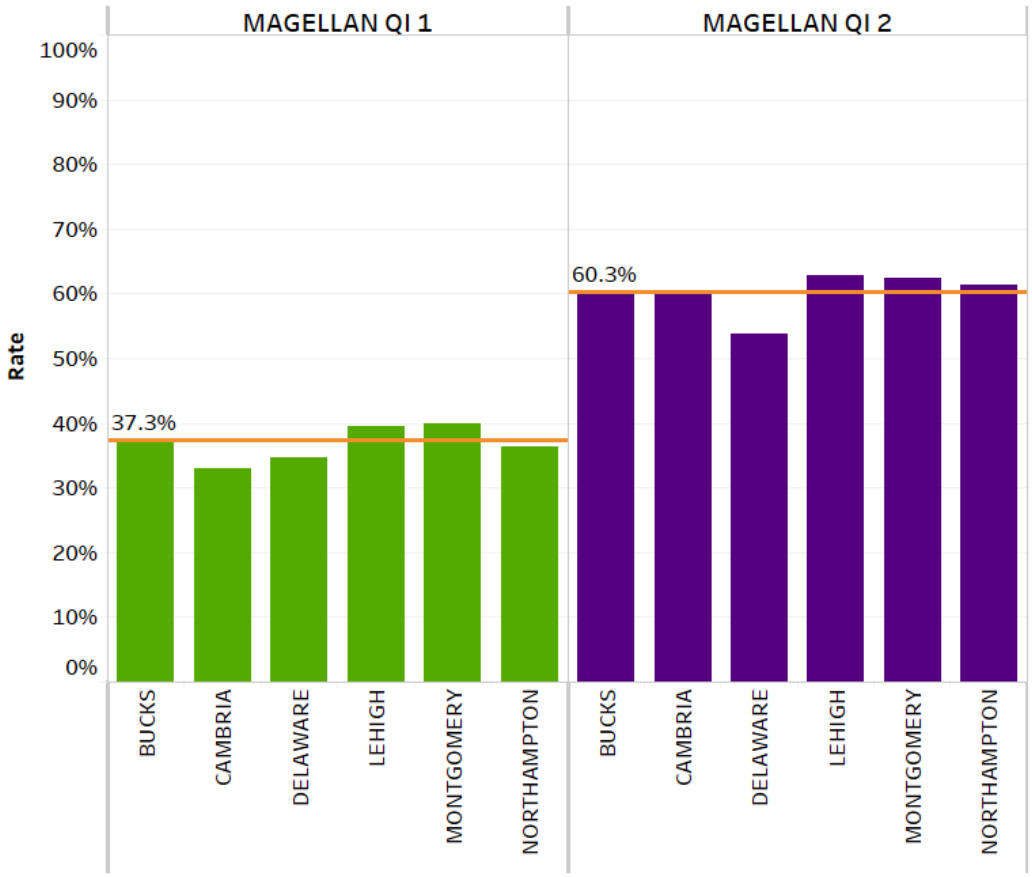

Figure 3.3: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (All Ages).

Figure 3.4 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than its statewide benchmark. QI 1 rates for Delaware and Cambria were statistically significantly below the MY 2018 QI 1 HC BH rate of 39.4% percentage points, ranging from 4.7 for Delaware to 6.3 for Cambria. The QI 2 rate for Lehigh was statistically significantly above the QI 2 HC BH rate of 60.2% by 2.7 percentage points. Delaware was statistically significantly below the QI 2 HC BH rate of 60.2% by 6.4 percentage points.

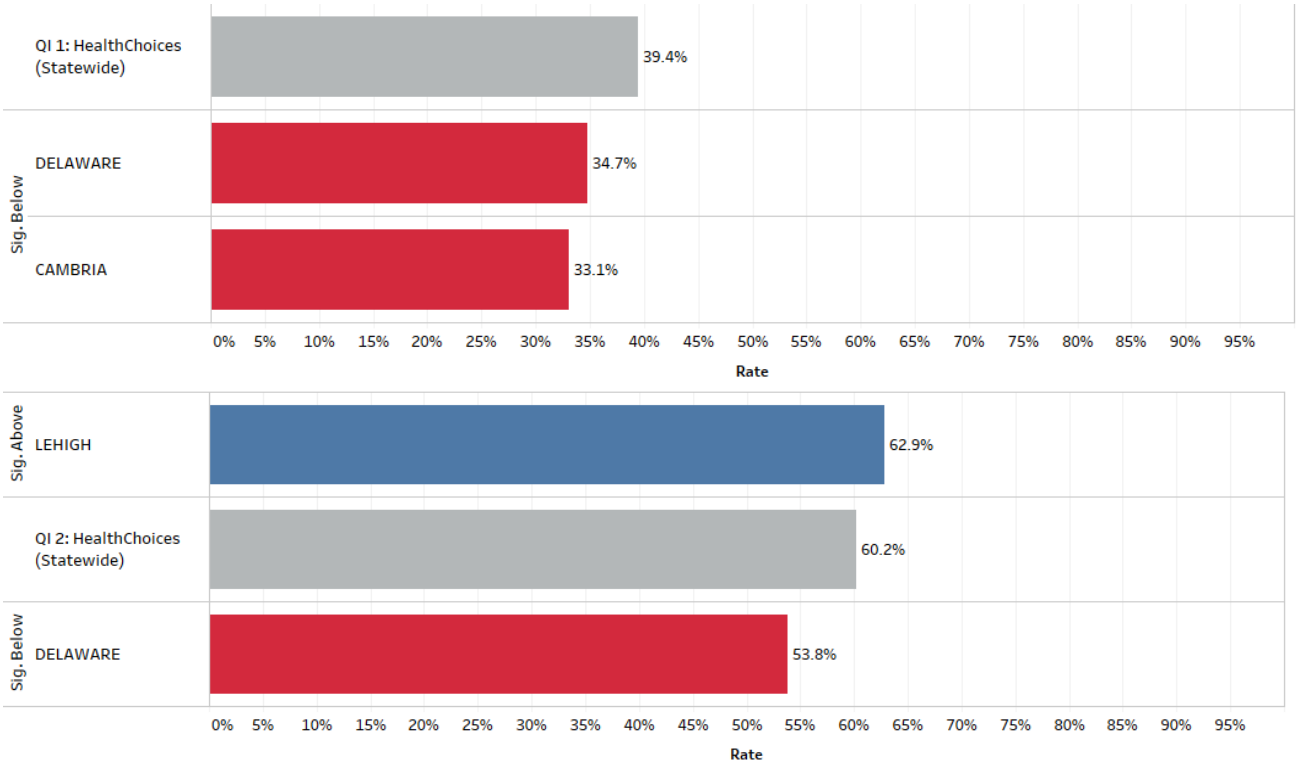

Figure 3.4: MBH Contractor MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (All Ages) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (All Ages).

(c) Age Group: 6–17 Years Old

The MY 2018 HealthChoices Aggregate rates in the 6 to 17 years old age group were 55.7% for QI 1 and 77.7% for QI 2 (**Table 3.3**). The MBH MY 2018 HEDIS rates for members ages 6 to 17 years old was 47.6% for QI 1 and 71.6% for QI 2. For QI 1 and 2 rates, there were no statistically significant changes from MY 2017 to MY 2018.

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

MY 2018							MY 2018 Rate Comparison	
				95% CI		MY 2017	To MY 2017	
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI1 – HEDIS 7-Day Follow-up (6-17 Years)								
HealthChoices (Statewide)	4592	8243	**55.7%**	54.6%	56.8%	55.1%	0.6	NO
Magellan	676	1421	**47.6%**	44.9%	50.2%	47.5%	0.1	NO
Bucks	112	234	**47.9%**	41.2%	54.5%	45.7%	2.1	NO
Cambria	43	104	**41.3%**	31.4%	51.3%	49.1%	-7.8	NO
Delaware	129	253	**51.0%**	44.6%	57.3%	45.4%	5.6	NO
Lehigh	134	278	**48.2%**	42.1%	54.3%	46.1%	2.1	NO
Montgomery	155	299	**51.8%**	46.0%	57.7%	52.9%	-1.0	NO
Northampton	103	253	**40.7%**	34.5%	47.0%	45.1%	-4.4	NO
QI2 – HEDIS 30-Day Follow-up (6-17 Years)								
HealthChoices (Statewide)	6406	8243	**77.7%**	76.8%	78.6%	78.7%	-0.9	NO
Magellan	1017	1421	**71.6%**	69.2%	73.9%	72.7%	-1.1	NO
Bucks	175	234	**74.8%**	69.0%	80.6%	72.6%	2.1	NO
Cambria	79	104	**76.0%**	67.3%	84.7%	80.7%	-4.7	NO
Delaware	177	253	**70.0%**	64.1%	75.8%	70.0%	-0.0	NO
Lehigh	201	278	**72.3%**	66.9%	77.7%	71.9%	0.4	NO
Montgomery	218	299	**72.9%**	67.7%	78.1%	73.6%	-0.6	NO
Northampton	167	253	**66.0%**	60.0%	72.0%	73.8%	-7.8	NO

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

Figure 3.5 is a graphical representation of the MY 2018 HEDIS FUH 7- and 30-Day follow-up rates in the 6 to 17 years old population for MBH and its associated HC BH Contractors. The orange line indicates the MCO average.

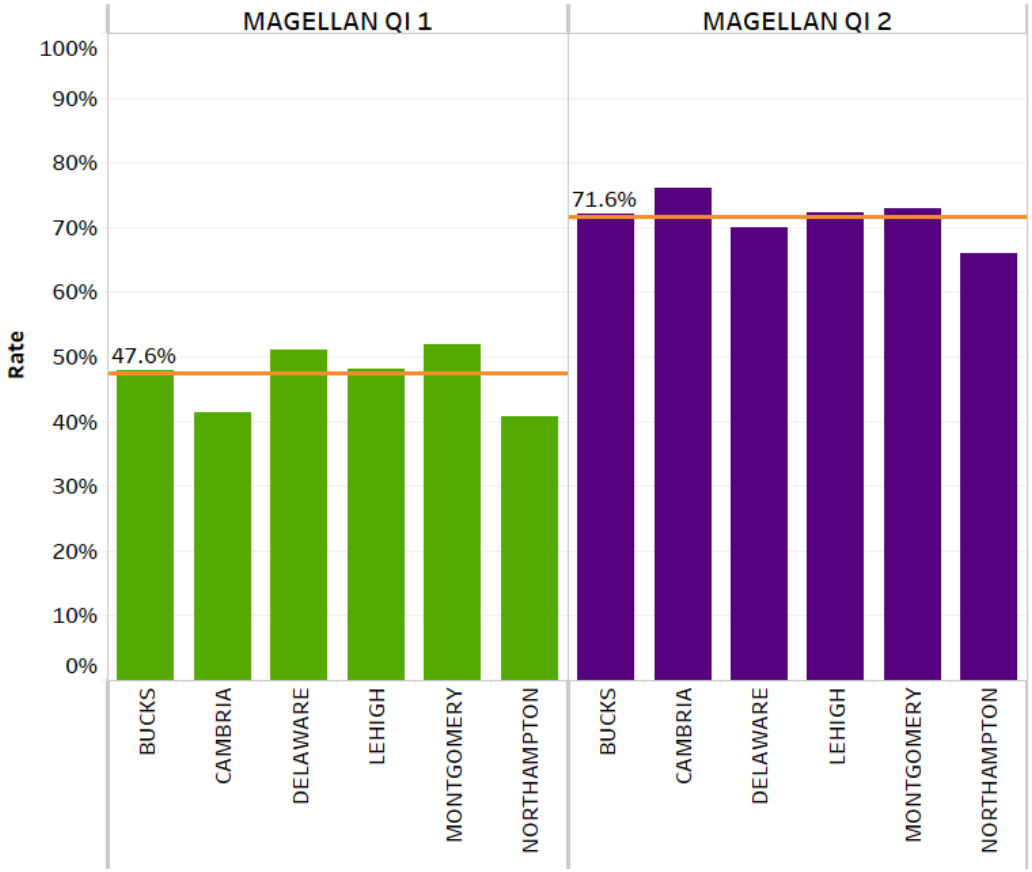

Figure 3.5: MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (6–17 Years).

Figure 3.6 shows the HC BH (Statewide) rates for this age cohort and the individual HC BH Contractor rates that were statistically significantly higher or lower than the statewide rates. QI 1 rates for Lehigh, Bucks, Cambria, and Northampton fell significantly below the MY 2018 QI 1 HC BH rate of 55.7% by percentage point differences, ranging from 7.5 for Lehigh to 15.0 for Northampton. QI 2 rates for Lehigh, Delaware, and Northampton were statistically significantly below the MY 2018 QI 2 HC BH rate of 77.7%, ranging from 5.4 (for Lehigh) to 11.7 (for Northampton) percentage points compared to the Statewide rate.

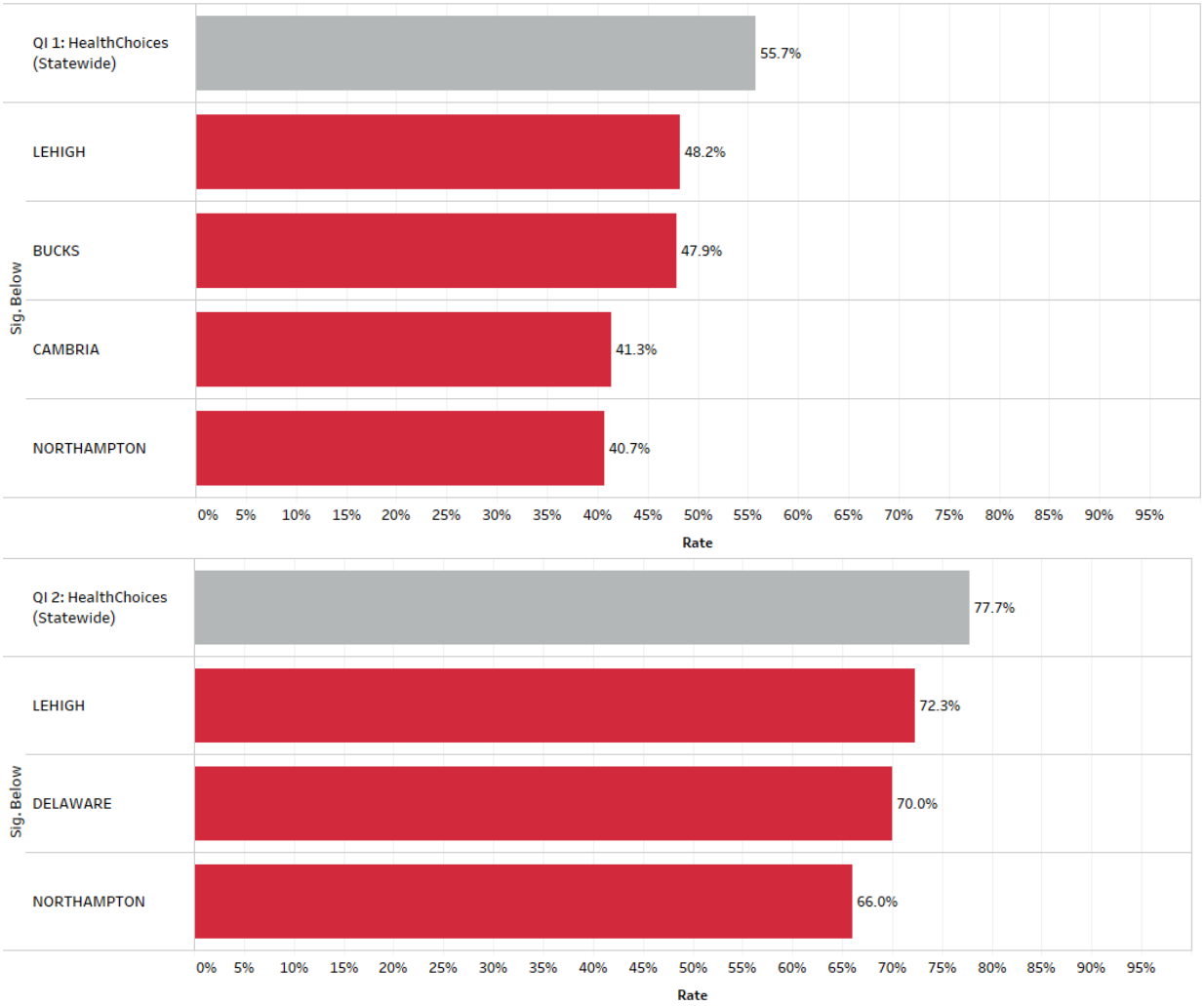

Figure 3.6: MBH Contractor MY 2018 HEDIS FUH 7- and 30-Day Follow-up Rates (6-17 Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS FUH Follow-up Rates (6–17 Years).

II: PA-Specific Follow-up Indicators

(a) Overall Population: 6+ Years Old

The MY 2018 HealthChoices Aggregate rates were 53.1% for QI A and 69.6% for QI B (**Table 3.4**). The rate for QI A was statistically significantly lower compared to MY 2017, with a decrease in 0.9 percentage points. The MY 2017 MBH QI A rate was 50.4%, which represents a 2.8 percentage point increase from the prior year, and the MBH QI B rate was 66.2%, which represents a 3.3 percentage point increase from the prior year. These year-to-year decreases were statistically significant.

From MY 2017 to MY 2018, only one contractor, Cambria, experienced a percentage point decrease in their QI A and QI B rates. Lehigh experienced an increase in its QI A rate by 5 percentage points, which was significant. Lehigh, Montgomery, and Northampton all saw significant increases in their QI B rates.

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

MY 2018						MY 2017	MY 2018 Rate Comparison To MY 2017	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-up (All Ages)								
Statewide	21746	40979	**53.1%**	52.6%	53.6%	52.2%	0.9	YES
Magellan	3571	7088	**50.4%**	49.2%	51.6%	47.6%	2.8	YES
Bucks	612	1222	**50.1%**	47.2%	52.9%	46.4%	3.7	NO
Cambria	277	605	**45.8%**	41.7%	49.8%	47.7%	-1.9	NO
Delaware	581	1252	**46.4%**	43.6%	49.2%	45.4%	1.1	NO
Lehigh	789	1513	**52.1%**	49.6%	54.7%	47.2%	5.0	YES
Montgomery	816	1521	**53.6%**	51.1%	56.2%	50.5%	3.2	NO
Northampton	496	975	**50.9%**	47.7%	54.1%	47.8%	3.0	NO
QI B – PA-Specific 30-Day Follow-up (All Ages)								
Statewide	28504	40979	**69.6%**	69.1%	70.0%	69.6%	-0.1	NO
Magellan	4693	7088	**66.2%**	65.1%	67.3%	63.0%	3.3	YES
Bucks	780	1222	**63.8%**	61.1%	66.6%	60.0%	3.9	NO
Cambria	396	605	**65.5%**	61.6%	69.3%	68.7%	-3.2	NO
Delaware	757	1252	**60.5%**	57.7%	63.2%	58.7%	1.7	NO
Lehigh	1034	1513	**68.3%**	66.0%	70.7%	64.5%	3.9	YES
Montgomery	1045	1521	**68.7%**	66.3%	71.1%	65.1%	3.6	YES
Northampton	681	975	**69.8%**	66.9%	72.8%	65.1%	4.8	YES

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

Figure 3.7 is a graphical representation of the MY 2018 PA-specific follow-up rates for MBH and its associated HC BH Contractors. The orange line indicates the MCO average.

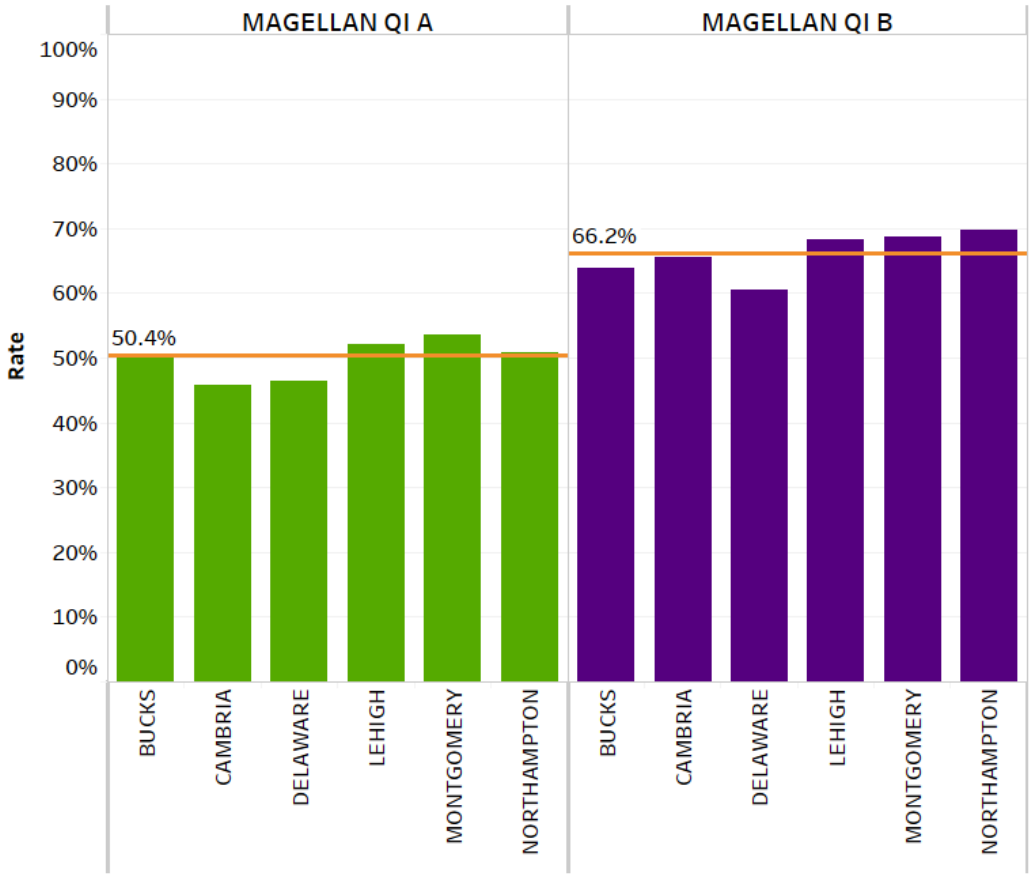

Figure 3.7: MY 2018 PA-Specific FUH 7- and 30-Day Follow-up Rates (All Ages).

Figure 3.8 shows the HC BH (Statewide) rates and the individual HC BH Contractor rates that were statistically significantly higher or lower than the Statewide benchmark. QI A rates were lower than the HC BH rate of 53.1% for Bucks, Delaware, and Cambria in MY 2018. QI B rates for Cambria, Bucks, and Delaware were also significantly below the HC BH rate of 69.6 for QI B.

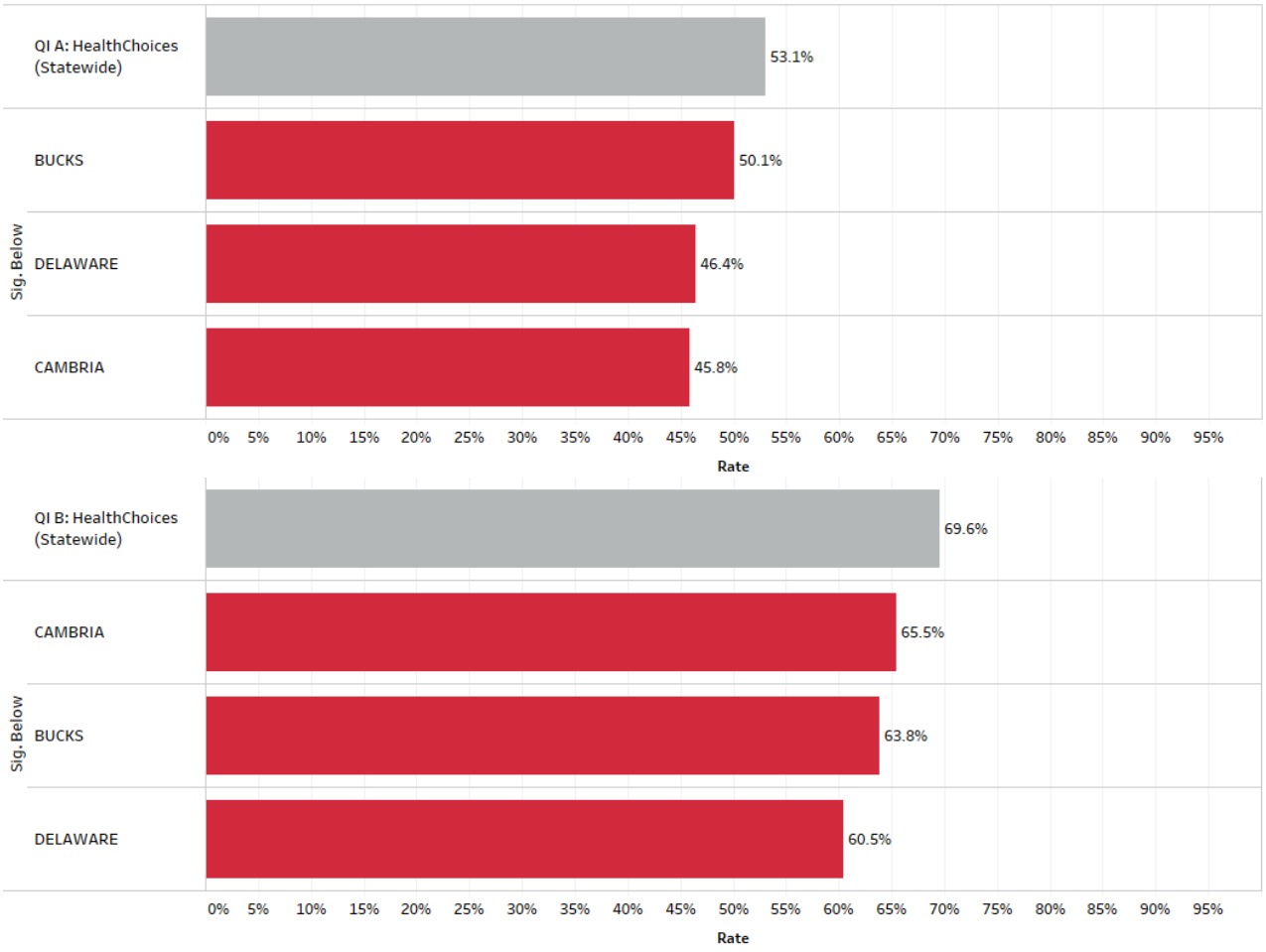

Figure 3.8: MBH Contractor MY 2018 PA-specific FUH 7- and 30-Day Follow-up Rates (All Ages) that are Significantly Different than HealthChoices (Statewide) MY 2018 PA-specific FUH Follow-up Rates (All Ages).

Conclusion and Recommendations

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

- The purpose of this re-measurement study is to inform OMHSAS, the HC BH Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2018, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their interventions. To that end, the HC BH Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health care follow-up. The HC BH Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable HC BH Contractor exceptions, FUH rates have, for the most part decreased (worsened) for the BH-MCO. In some cases, the change was a continuation or even acceleration of existing trends. As previously noted, this analysis was not able to carry out more detailed examination of rates associated with the Medicaid expansion subpopulation. The potential impact on rates from the Medicaid expansion in 2018 were not evaluated in this report, although comparisons to the non-Medicaid population were carried out in a separate 2019 (MY 2018) FUH "Rates Report" produced by the EQRO and which, for the first time this year, is being made available to BH MCOs in an interactive Tableau® workbook. BH-MCOs and HC BH Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For one, it is important for BH-MCOs and HC BH Contractors to analyze performance rates by racial and ethnic categories and to target the demographic populations that do not perform as well as their counterparts. The BH-MCOs and HC BH Contractors should continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance. The aforementioned 2019 (MY 2018) FUH Rates Report is one source BH MCOs can use to investigate potential health disparities in FUH.
- BH-MCOs and HC BH Contractors are encouraged to review the 2019 (MY 2018) FUH Rates Report in conjunction with the corresponding 2019 (MY 2018) inpatient psychiatric readmission Rates (REA) Report. The BH-MCOs and HC BH contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-up After Hospitalization for Mental Illness, OMHSAS elected to retain and re-measure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the performance measure for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and re-measurement of the performance measure for validation soon thereafter for MY 2007, and then for MY 2008. Re-measurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2018 study conducted in 2019 was the tenth re-measurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and

revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2018. This measure continued to be of interest to OMHSAS for the purposes of comparing HC BH Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

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

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

Eligible Population

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

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

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

Methodology

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

Performance Goals

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

Findings

BH-MCO and HC BH Contractor Results

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

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

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

The MY 2018 HealthChoices Aggregate (Statewide) readmission rate was 13.7%, which was not statistically significant different from the MY 2017 HealthChoices Aggregate rate of 13.4% (**Table 3.5**). The MBH MY 2017 readmission rate was 16.0%. The MY 2017 rate was 15.7%; this change was not statistically significant. MBH did not meet the performance goal of a readmission rate at or below 10.0% in MY 2018.

From MY 2017 to MY 2018, the REA rate of one of MBH's HC BH Contractors, Lehigh, statistically significantly worsened. The psychiatric readmission rate for Lehigh increased 2.6 percentage points from 16.2% to 18.8%. None of the HC BH Contractors with MBH met or beat the OMHSAS performance goal of 10%.

Table 3.5: MY 2018 REA Readmission Indicators

MY 2018							MY 2017 %	MY 2018 Rate Comparison To MY 2017	
				95% CI					
Measure	(N)	(D)	%	Lower	Upper	Goal Met?		PPD	SSD
Inpatient Readmission									
Statewide	7188	52290	**13.7%**	13.5%	14.0%	No	13.4%	0.3	NO
Magellan	1538	9602	**16.0%**	15.3%	16.8%	No	15.7%	0.3	NO
Bucks	292	1745	**16.7%**	15.0%	18.5%	No	17.3%	-0.5	NO
Cambria	117	768	**15.2%**	12.6%	17.8%	No	15.4%	-0.2	NO
Delaware	228	1683	**13.5%**	11.9%	15.2%	No	13.6%	-0.1	NO
Lehigh	390	2077	**18.8%**	17.1%	20.5%	No	16.2%	2.6	YES
Montgomery	320	2046	**15.6%**	14.0%	17.2%	No	15.9%	-0.2	NO
Northampton	191	1283	**14.9%**	12.9%	16.9%	No	15.7%	-0.9	NO

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

Figure 3.9 is a graphical representation of the MY 2018 readmission rates for MBH HC BH Contractors compared to the orange line representing Magellan's performance goal of 16.0% for MY 2018.

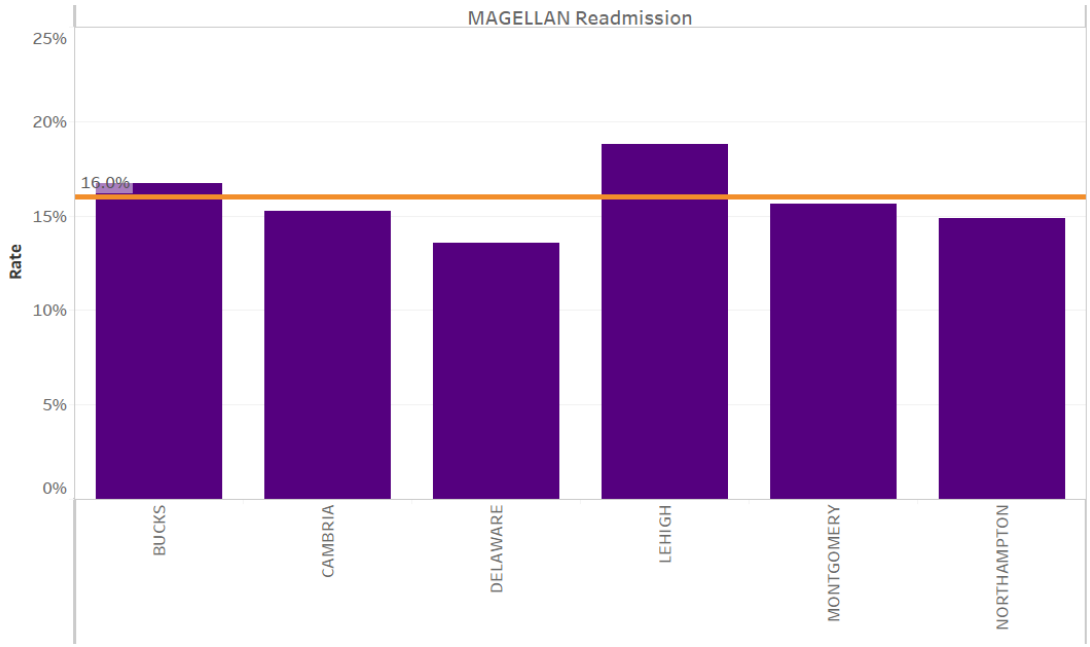

Figure 3.9: MY 2018 REA Readmission Rates.

Figure 3.10 shows the Health Choices BH (Statewide) readmission rate and the individual MBH HC BH Contractors that performed statistically significantly higher (red) or lower (blue) than the Statewide rate. Lehigh, Bucks, and Montgomery demonstrated readmission rates that were statistically significantly higher (worse) than the Statewide rate, ranging from 1.9 to 5.1 percentage points higher than the Statewide rate.

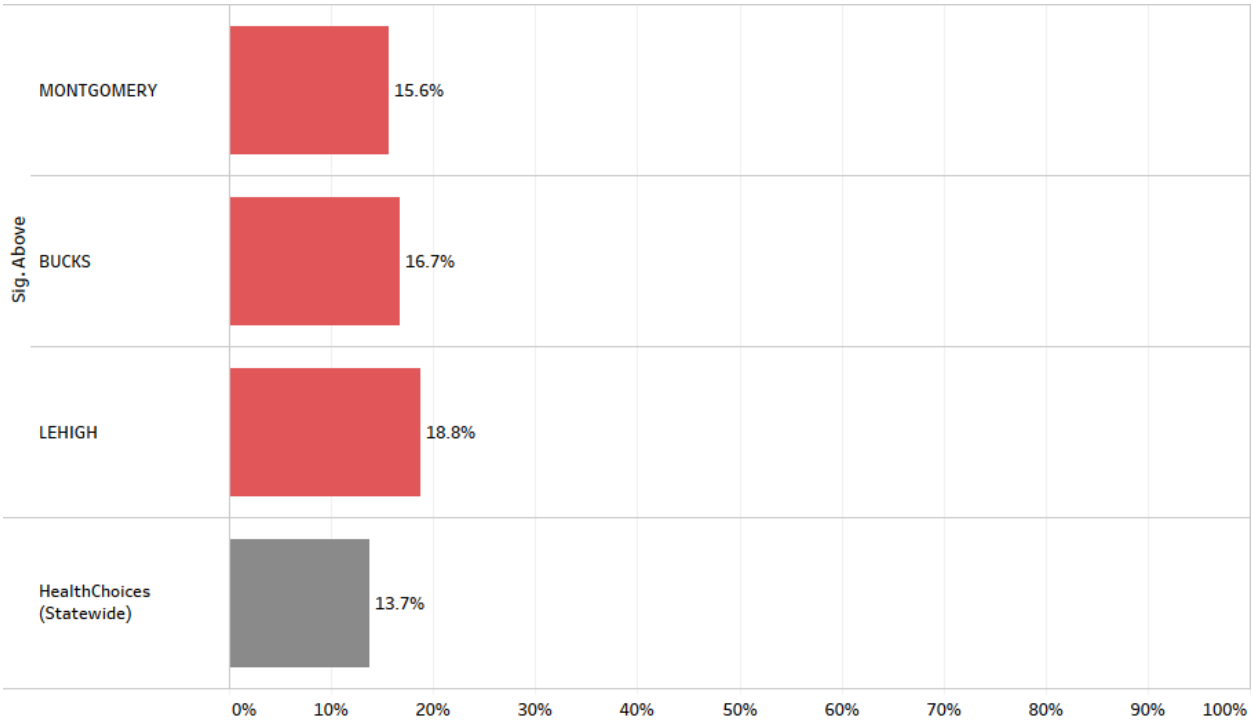

Figure 3.10: MBH Contractor MY 2018 REA Readmission Rates that are Significantly Different than HealthChoices (Statewide) MY 2018 REA Readmission Rates.

Conclusion and Recommendations

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

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

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

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

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

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

measure assessed the percentage of members who had a qualifying encounter with a diagnosis of alcohol or other drug dependence (AOD) who had an initiation visit within 14 days of the initial encounter, and the percentage of members who also had at least 2 visits within 34 days after the initiation visit.

Quality Indicator Significance

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

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

Eligible Population[2]

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

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

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

Numerators

This measure has two numerators:

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

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

Methodology

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

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

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

Limitations

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

Findings

BH-MCO and HC BH Contractor Results

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

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

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

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

(a) Age Group: 13–17 Years Old

The MY 2018 HealthChoices Aggregate (Statewide) rates in the 13–17 years age group were 44.7% for Initiation and 31.8% for Engagement (**Table 3.6**). The Engagement rate was statistically significantly lower than the MY 2017 13-17 years HealthChoices Aggregate rate of 34.6%. In MY 2017, the HealthChoices Aggregate rate for Initiation was between the HEDIS percentiles for the 50th and 75th percentiles, while the HealthChoices Aggregate rate for Engagement was above the 75th percentile. The MBH MY 2017 13–17 years Initiation rate decreased by 0.6 percentage points to 37.3%, which was not statistically significant compared to the MY 2017 MBH rate of 37.9% (**Table 3.6**). Similarly, the MBH MY 2018 13–17 years Engagement rate was 25.9%, which was not statistically significantly different from the MY 2017 rate of 30.2%. The MBH Initiation rate for MY 2017 was between the HEDIS 25th and 50th percentile, but MBH's Engagement rate came in at or above the HEDIS 75th percentile.

None of MBH's HC BH Contractors had sufficiently large denominators to test for year-over-year change, except Delaware and Bucks, which rates did not change significantly from MY 2017 to MY 2018.

For Initiation, one of the MBH HC BH contractors performed between the 50th and 75th percentiles (Buck), two performed between the 25th and 50th percentiles (Cambria and Northampton), and three performed below the 25th percentile (Delaware, Lehigh, and Northampton). Most of the MBH Contractors did better on the Engagement rate than the Initiation rate, returning rates above the 75th percentile except for Lehigh and Montgomery which performed below the 25th percentile.

Table 3.6: MY 2017 IET Initiation and Engagement Indicators (13–17 Years)

MY 2017						MY 2017 %	MY 2018 Rate Comparison		
				95% CI			To MY 2017		
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	To HEDIS 2019 Percentiles
Numerator 1: Initiation of AOD Treatment (13–17) Years									
Statewide	1204	2692	**44.7%**	42.8%	46.6%	46.3%	-1.6	NO	Below 75th Percentile, Above 50th Percentile
Magellan	196	526	**37.3%**	33.0%	41.5%	37.9%	-0.6	NO	Below 50th Percentile, Above 25th Percentile
Bucks	48	105	**45.7%**	35.7%	55.7%	37.9%	7.8	NO	Below 75th Percentile, Above 50th Percentile
Cambria	7	19	**36.8%**	N/A	N/A	37.9%	-1.0	N/A	Below 50th Percentile, Above 25th Percentile
Delaware	43	130	**33.1%**	24.6%	41.5%	37.9%	-4.8	NO	Below 25th Percentile
Lehigh	32	94	**34.0%**	N/A	N/A	37.9%	-3.8	N/A	Below 25th Percentile
Montgomery	27	80	**33.8%**	N/A	N/A	37.9%	-4.1	N/A	Below 25th Percentile
Northampton	39	98	**39.8%**	N/A	N/A	37.9%	1.9	N/A	Below 50th Percentile, Above 25th Percentile
Numerator 2: Engagement of AOD Treatment (13–17) Years									
Statewide	855	2692	**31.8%**	30.0%	33.5%	34.6%	-2.9	YES	At or Above 75th Percentile
Magellan	136	526	**25.9%**	22.0%	29.7%	30.2%	-4.4	NO	At or Above 75th Percentile
Bucks	35	105	**33.3%**	23.8%	42.8%	30.2%	3.1	NO	At or Above 75th Percentile
Cambria	6	19	**31.6%**	N/A	N/A	30.2%	1.4	N/A	At or Above 75th Percentile
Delaware	34	130	**26.2%**	18.2%	34.1%	30.2%	-4.1	NO	At or Above 75th Percentile
Lehigh	18	94	**19.1%**	N/A	N/A	30.2%	-11.1	N/A	Below 75th Percentile, Above 50th Percentile
Montgomery	16	80	**20.0%**	N/A	N/A	30.2%	-10.2	N/A	Below 75th Percentile, Above 50th Percentile
Northampton	27	98	**27.6%**	N/A	N/A	30.2%	-2.7	N/A	At or Above 75th Percentile

Note: Due to rounding, a PPD value may slightly diverge from the difference between the MY 2018 and MY 2017 rates.
N: numerator; D: denominator; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; CI: confidence interval; PPD: percentage point difference; SSD: statistically significant difference; N/A: Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Figure 3.11 is a graphical representation of the 13–17 years MY 2018 HEDIS Initiation and Engagement rates for MBH and its associated HC BH Contractors. The orange line indicates the MCO average.

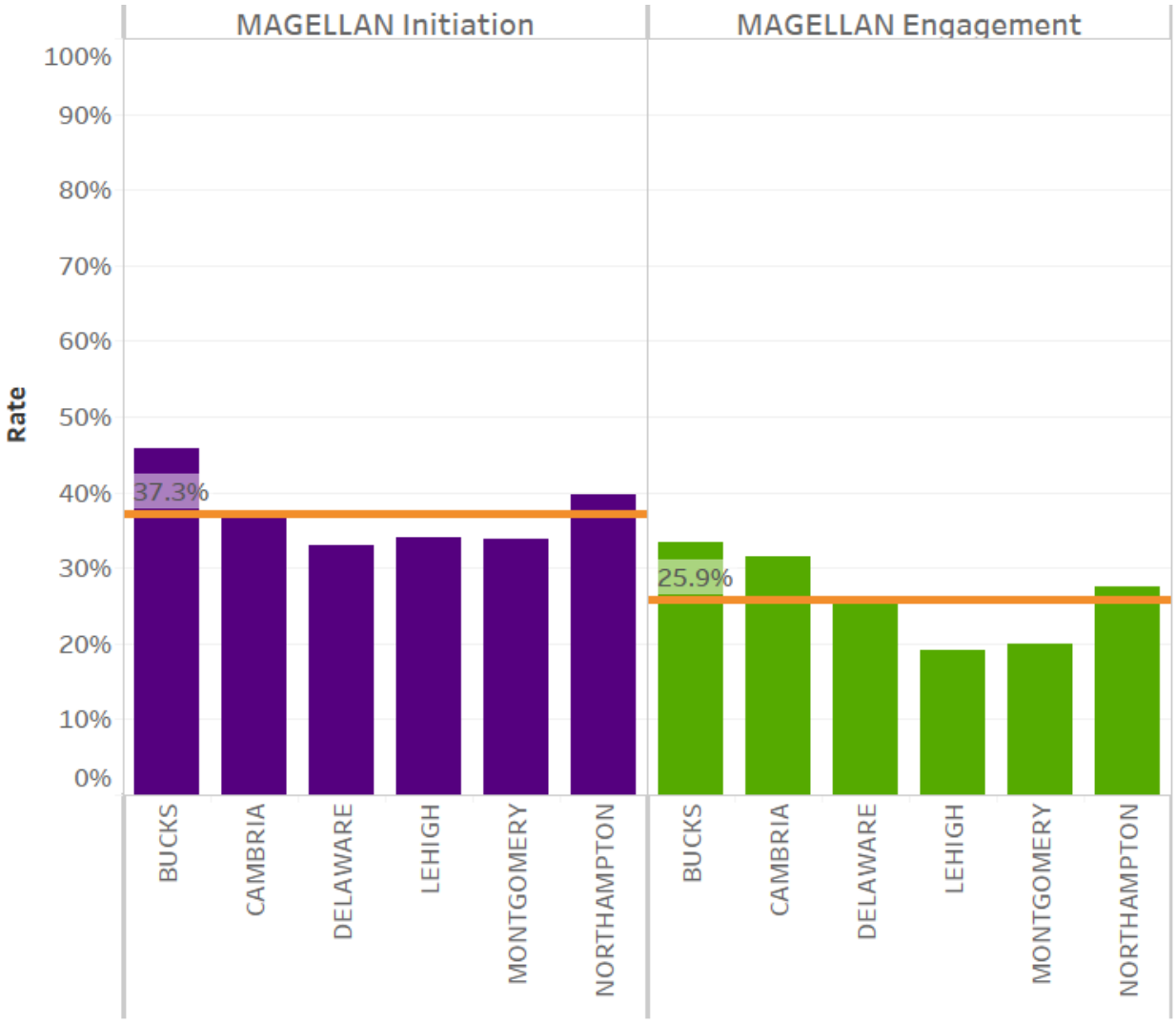

Figure 3.11: MY 2018 IET Initiation and Engagement Rates (13–17 Years).

Figure 3.12 shows the HealthChoices HC BH Contractor Average rates for this age cohort and the individual MBH HC BH Contractor rates that would have been statistically significantly higher or lower than the HealthChoices HC BH Statewide rate. In MY 2018, Delaware was the only MBH HC BH Contractor with sufficient denominator counts showing the rate as significantly below the Statewide rate for Initiation. For Engagement, none of the MBH HC BH Contractors with sufficient denominator counts to test were statistically significantly different from the Statewide rates.

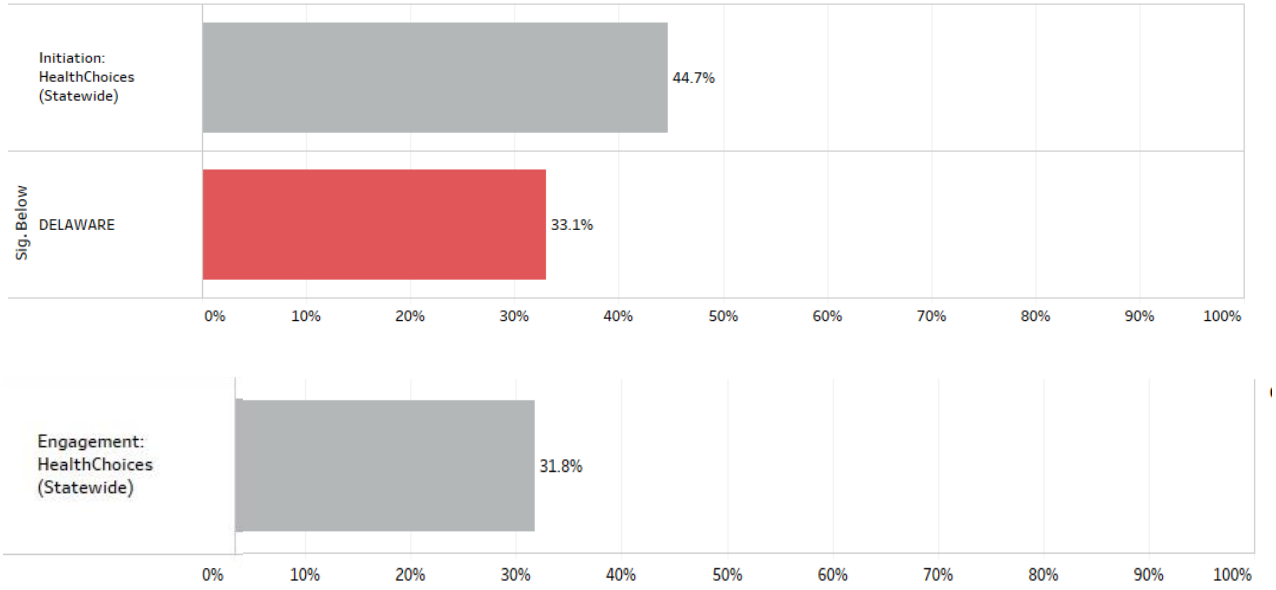

Figure 3.12: MBH Contractor MY 2018 HEDIS IET Rates (13-17 Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS IET Rates (13–17 Years).

(b) Age Group: 18+ Years Old

The MY 2018 HealthChoices Aggregate rates in the 18+ years age group were 41.9% for Initiation and 28.3% for Engagement (**Table 3.7**). Both rates were statistically significantly different from the corresponding MY 2017 rates: the HealthChoices Aggregate Initiation rate increased by 0.8 percentage points and the Engagement rate decreased by 5.3 percentage points from the prior year. The MY 2017 HealthChoices Aggregate Initiation rate in this age cohort was between the HEDIS 25th and 50th percentiles for 2018, while the Engagement rate was at or above the 75th percentiles.

The MBH MY 2018 Initiation rate for the 18+ year population was 39.0% (**Table 3.7**). This rate was below the HEDIS 50th percentile for 2018 but was statistically significantly higher than the MY 2017 rate by 2.8 percentage points. The MBH MY 2018 Engagement rate for this age cohort was 24.2% and was at or above the HEDIS 75th percentile for 2018. The MBH Engagement rate for this age group was statistically significantly lower than the MY 2017 rate by 3.8 percentage points.

As shown in **Table 3.7**, MBH Contractors struggled on the IET Initiation sub-measure: Cambria, Lehigh, and Northampton returned rates below the HEDIS 25th percentile. Overall, the MBH Contractors performed better on the Engagement submeasure—all of the Contractors met the OMHSAS goal of achieving the HEDIS 75th percentile—compared to the Initiation submeasure.

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

MY 2018						MY 2017 %	MY 2018 Rate Comparison		
				95% CI			To MY 2017		
Measure	(N)	(D)	%	Lower	Upper		PPD	SSD	To HEDIS 2019 Percentiles
Numerator 1: Initiation of AOD Treatment (18+ Years)									
Statewide	24954	59586	**41.9%**	41.5%	42.3%	41.1%	0.8	YES	Below 50th Percentile, Above 25th Percentile
Magellan	3709	9520	**39.0%**	38.0%	39.9%	36.2%	2.8	YES	Below 50th Percentile, Above 25th Percentile
Bucks	849	2044	**41.5%**	39.4%	43.7%	36.2%	5.4	YES	Below 50th Percentile, Above 25th Percentile
Cambria	151	459	**32.9%**	28.5%	37.3%	36.2%	-3.3	NO	Below 25th Percentile
Delaware	1022	2475	**41.3%**	39.3%	43.3%	36.2%	5.1	YES	Below 50th Percentile, Above 25th Percentile
Lehigh	547	1525	**35.9%**	33.4%	38.3%	36.2%	-0.3	NO	Below 25th Percentile
Montgomery	807	2023	**39.9%**	37.7%	42.0%	36.2%	3.7	YES	Below 50th Percentile, Above 25th Percentile
Northampton	333	994	**33.5%**	30.5%	36.5%	36.2%	-2.7	NO	Below 25th Percentile
Numerator 2: Engagement of AOD Treatment (18+ Years)									
Statewide	16886	59586	**28.3%**	28.0%	28.7%	33.7%	-5.3	YES	At or Above 75th Percentile
Magellan	2303	9520	**24.2%**	23.3%	25.1%	28.0%	-3.8	YES	At or Above 75th Percentile
Bucks	589	2044	**28.8%**	26.8%	30.8%	28.0%	0.9	NO	At or Above 75th Percentile
Cambria	89	459	**19.4%**	15.7%	23.1%	28.0%	-8.6	YES	At or Above 75th Percentile
Delaware	580	2475	**23.4%**	21.7%	25.1%	28.0%	-4.5	YES	At or Above 75th Percentile
Lehigh	319	1525	**20.9%**	18.8%	23.0%	28.0%	-7.0	YES	At or Above 75th Percentile
Montgomery	542	2023	**26.8%**	24.8%	28.7%	28.0%	-1.2	NO	At or Above 75th Percentile
Northampton	184	994	**18.5%**	16.0%	21.0%	28.0%	-9.5	YES	At or Above 75th Percentile

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

Figure 3.13 is a graphical representation MY 2018 IET rates for MBH and its associated HC BH Contractors for the 18+ years age group.

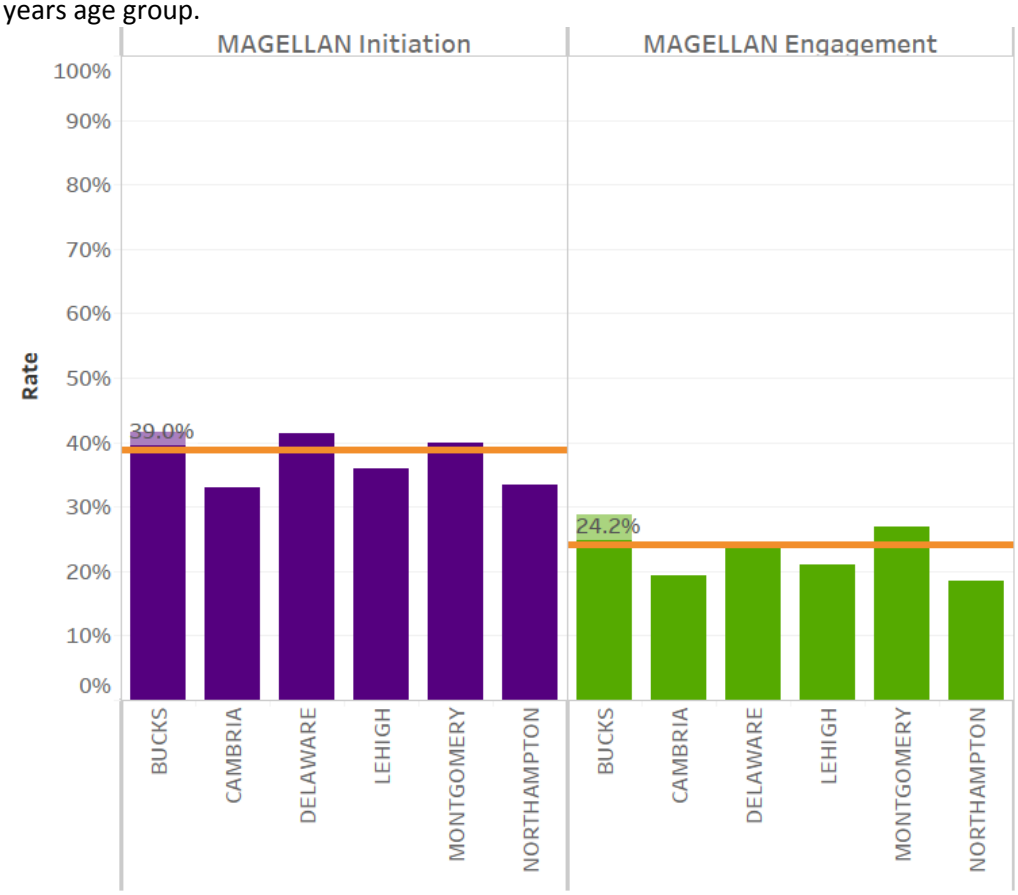

Figure 3.13: MY 2018 IET Initiation and Engagement Rates (18+ Years).

Figure 3.14 shows the HealthChoices HC BH Statewide rates and individual MBH HC BH Contractors that performed statistically significantly higher or lower than the Statewide rate. Three (3) of the 6 Contractors (Lehigh, Northampton, and Cambria) produced Initiation rates statistically significantly lower than the Statewide rate of 41.9%. Four of the contractors (Lehigh, Delaware, Cambria, and Northampton) also turned in Engagement rates that were statistically significantly lower than the Statewide rate by between 4.9 and 9.8 percentage points.

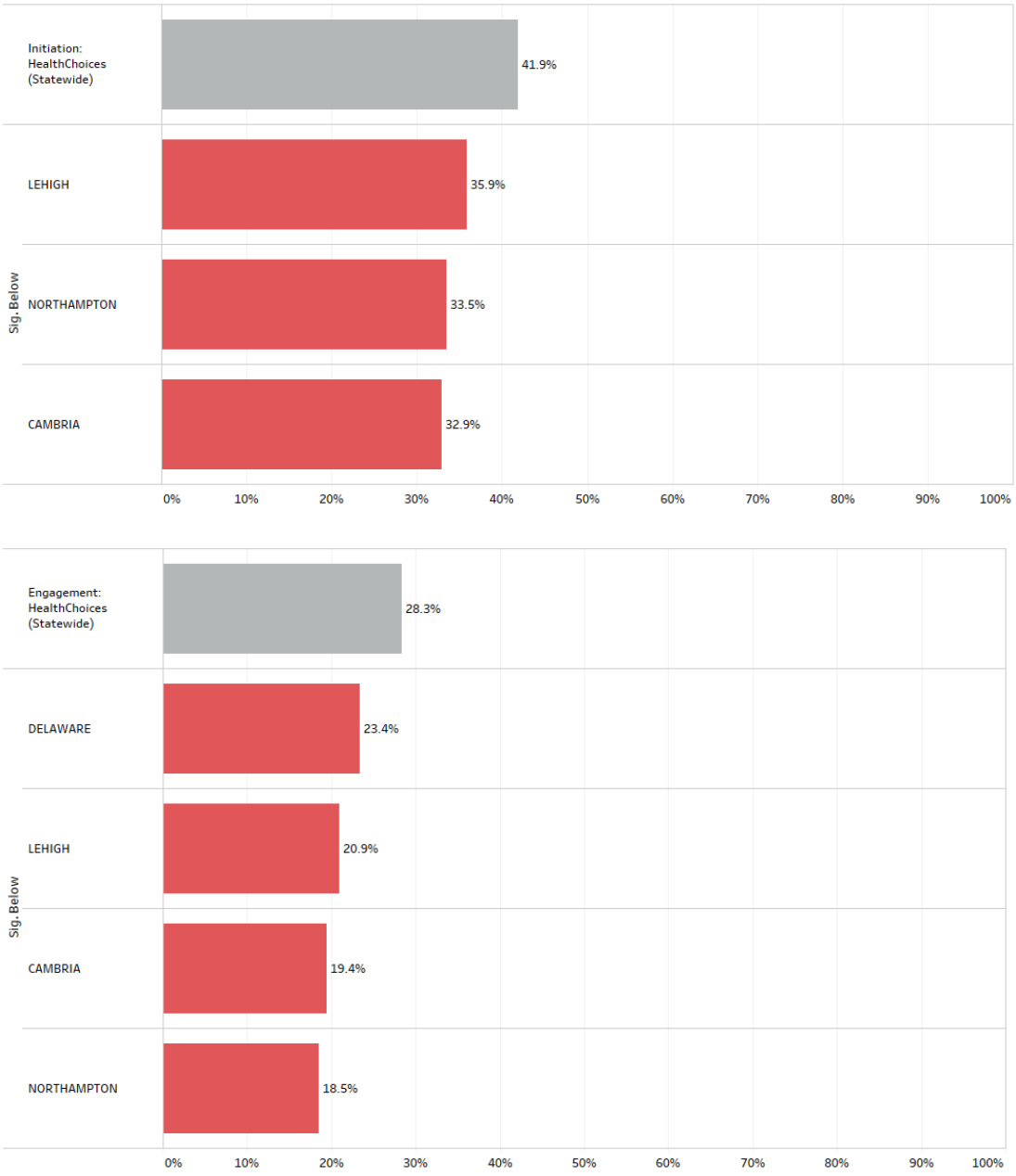

Figure 3.14: MBH Contractor MY 2018 HEDIS IET Rates (18+ Years) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS IET Rates (18+ Years).

(c) Age Group: 13+ Years Old

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

The MBH MY 2018 Initiation rate for the 13+ year population was 38.9% (**Table 3.8**). This rate was below the HEDIS 50th percentile for 2018 but with a statistically significant increase of 2.6 percentage points compared to the MY 2017 rate. The MBH MY 2018 Engagement rate was 24.3%, which was at or above the HEDIS 2019 75th percentile. The MBH Engagement rate was statistically significantly lower than the MY 2017 rate of 28.1%.

As presented in **Table 3.8**, many of the HC BH Contractor rates statistically significantly increased for both Initiation and Engagement rates compared to MY 2017. For Initiation rates, however, Cambria, Lehigh, and Northampton performed below the 25th percentile. MBH Contractors performed better on the Engagement sub-measure than in Initiation, meeting or exceeding the HEDIS 75th percentile benchmark.

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

MY 2018						MY 2017	MY 2018 Rate Comparison		
				95% CI			To MY 2017		
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	To HEDIS 2019 Percentiles
Numerator 1: Initiation of AOD Treatment (All Ages)									
Statewide	26158	62278	**42.0%**	41.6%	42.4%	41.3%	0.7	YES	Below 50th Percentile, Above 25th Percentile
Magellan	3905	10046	**38.9%**	37.9%	39.8%	36.2%	2.6	YES	Below 50th Percentile, Above 25th Percentile
Bucks	897	2149	**41.7%**	39.6%	43.8%	36.2%	5.5	YES	Below 50th Percentile, Above 25th Percentile
Cambria	158	478	**33.1%**	28.7%	37.4%	36.2%	-3.2	NO	Below 25th Percentile
Delaware	1065	2605	**40.9%**	39.0%	42.8%	36.2%	4.6	YES	Below 50th Percentile, Above 25th Percentile
Lehigh	579	1619	**35.8%**	33.4%	38.1%	36.2%	-0.5	NO	Below 25th Percentile
Montgomery	834	2103	**39.7%**	37.5%	41.8%	36.2%	3.4	YES	Below 50th Percentile, Above 25th Percentile
Northampton	372	1092	**34.1%**	31.2%	36.9%	36.2%	-2.2	NO	Below 25th Percentile
Numerator 2: Engagement of AOD Treatment (All Ages)									
Statewide	17741	62278	**28.5%**	28.1%	28.8%	33.7%	-5.2	YES	At or Above 75th Percentile
Magellan	2439	10046	**24.3%**	23.4%	25.1%	28.1%	-3.8	YES	At or Above 75th Percentile
Bucks	624	2149	**29.0%**	27.1%	31.0%	28.1%	1.0	NO	At or Above 75th Percentile
Cambria	95	478	**19.9%**	16.2%	23.6%	28.1%	-8.2	YES	At or Above 75th Percentile
Delaware	614	2605	**23.6%**	21.9%	25.2%	28.1%	-4.5	YES	At or Above 75th Percentile
Lehigh	337	1619	**20.8%**	18.8%	22.8%	28.1%	-7.2	YES	At or Above 75th Percentile
Montgomery	671	2,281	**29.4 %**	27.5%	31.3%	13.4%	16.0	YES	At or above 75th percentile
Northampton	295	1,250	**23.6 %**	21.2%	26.0%	15.8%	7.8	YES	At or above 75th percentile

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

Figure 3.15 is a graphical representation MY 2018 IET rates for MBH and its associated HC BH Contractors for the 13+ years age group. The orange line indicates the MCO average.

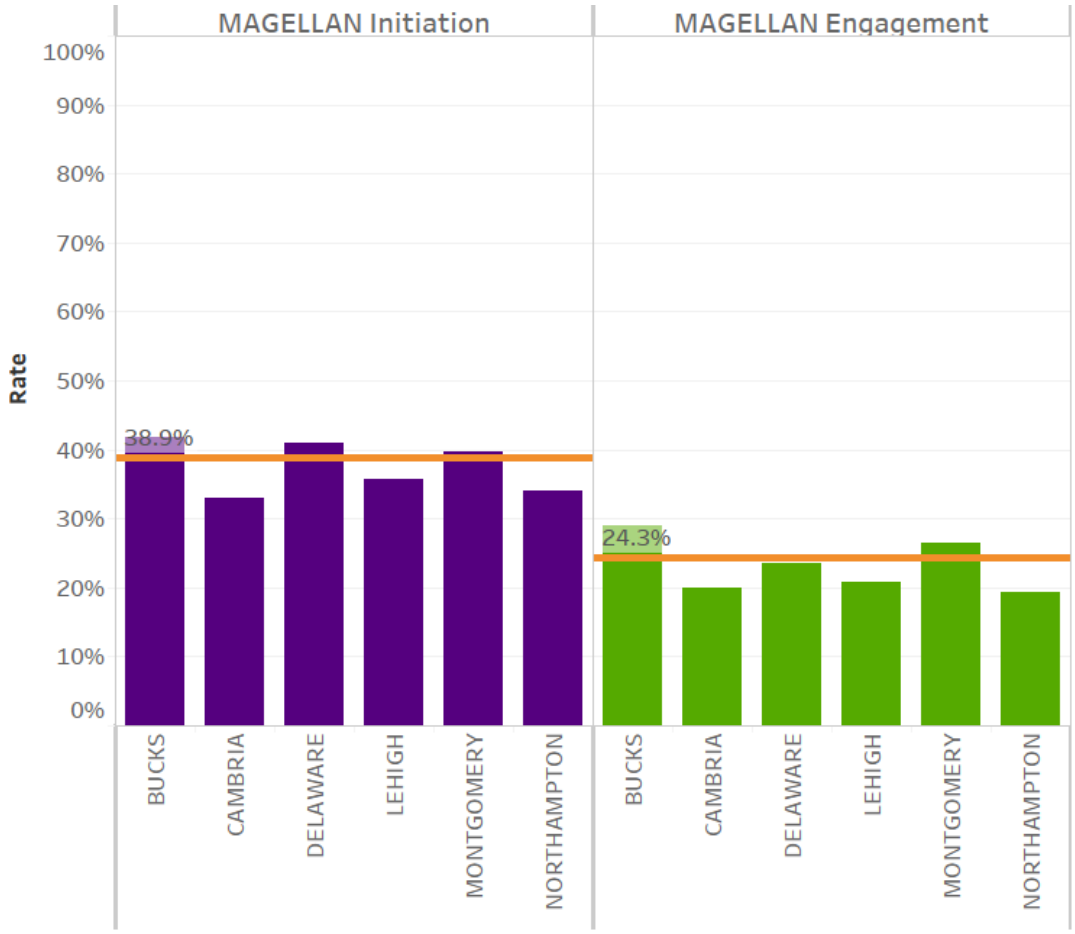

Figure 3.15: MY 2018 IET Initiation and Engagement Rates (All Ages).

Figure 3.16 shows the HealthChoices HC BH Contractor Average rates and individual MBH HC BH Contractors that performed statistically significantly higher or lower than the HC BH Contractor Average. Montgomery, Lehigh, Northampton, and Cambria produced Initiation rates statistically significantly lower than the Statewide rate of 42.0%. Delaware, Lehigh, Cambria, and Northampton also turned in Engagement rates that were statistically significantly lower than the Statewide rate of 28.5%.

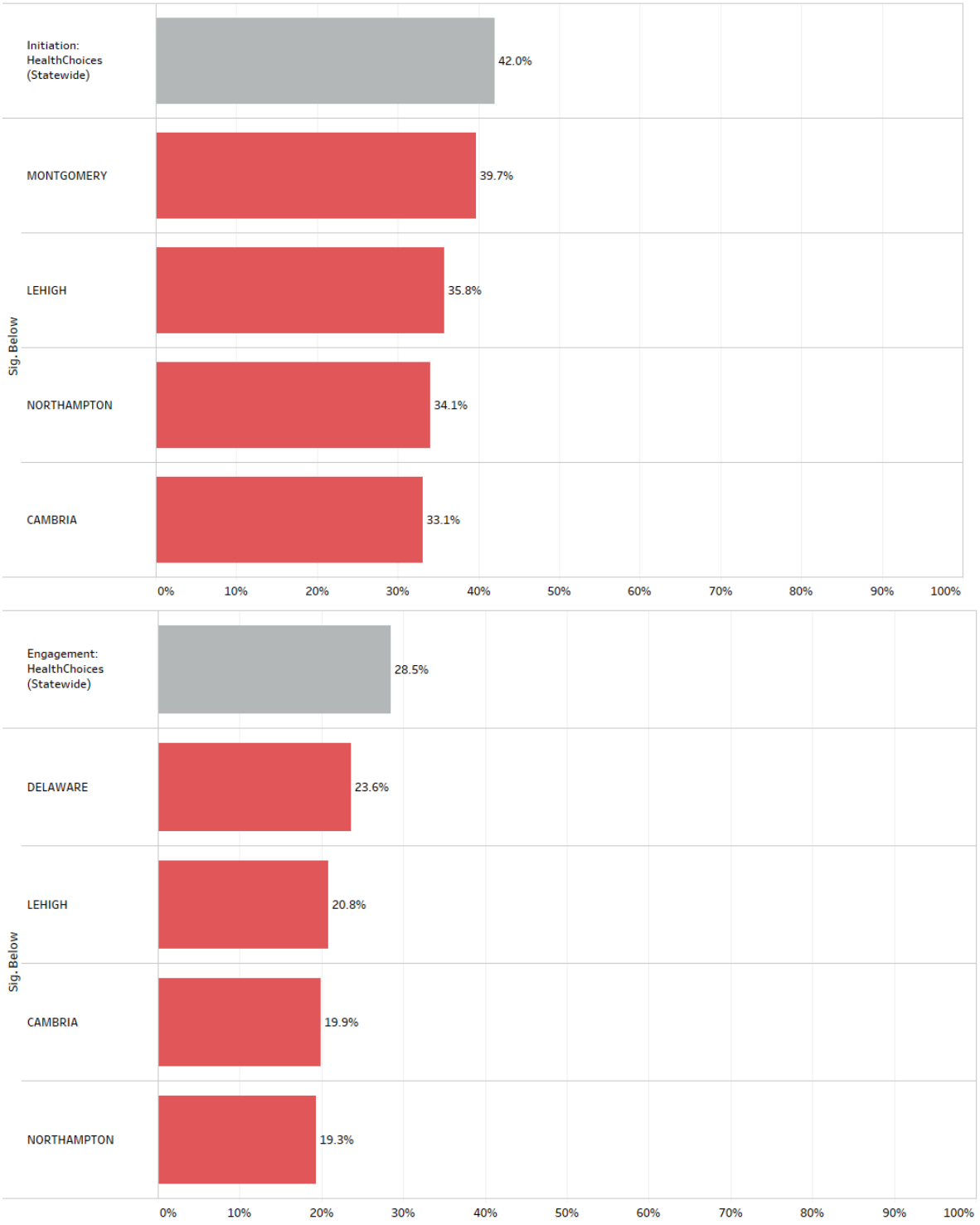

Figure 3.16: MBH Contractor MY 2018 HEDIS IET Rates (All Ages) that are Significantly Different than HealthChoices (Statewide) MY 2018 HEDIS IET Rates (All Ages).

Conclusion and Recommendations

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

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

IV: Quality Studies

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

Certified Community Behavioral Health Clinics

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

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

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

interpreted with caution to the extent that they cover a period in which clinics were still learning to fully implement their CCBHC quality and measurement programs.

Demonstration Year 1 Results

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

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

Table 4.1 CCBHC Quality Performance compared to Statewide and National Benchmarks

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

Measure	CCBHC weighted average	Comparison		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	27.1%	55.7%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 7 day	36.3%	51.1%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 30 day	37.1%	74.0%		
Antidepressant Medication Management - Acute	46.3%	51.4%		
Antidepressant Medication Management - Continuation	25.5%	37.2%		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	46.3%	69.0%		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.0%	88.1%		
Plan All-Cause Readmissions Rate (lower is better)	8.0%	17.0%		
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	13.2%		12.5%	MIPS 2019 (eCQMs)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	23.3%		8.1%	MIPS 2019 (eCQMs)
Screening for Depression and Follow-Up Plan	34.7%		18.0%	MIPS 2019 (eCQMs)
Depression Remission at Twelve Months	6.0%		3.0%	MIPS 2019 (eCQMs)
Body Mass Index (BMI) Screening and Follow-Up Plan	43.5%		58.9%	MIPS 2018 (Claims)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	56.0%		72.5%	HEDIS 2019 Quality Compass 50th Percentile
Tobacco Use: Screening and Cessation Intervention	50.0%		61.8%	MIPS 2019 (CMS Web Interface Measures)
Unhealthy Alcohol Use: Screening and Brief Counseling	38.6%		63.9%	MIPS 2018 (Registry)

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

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

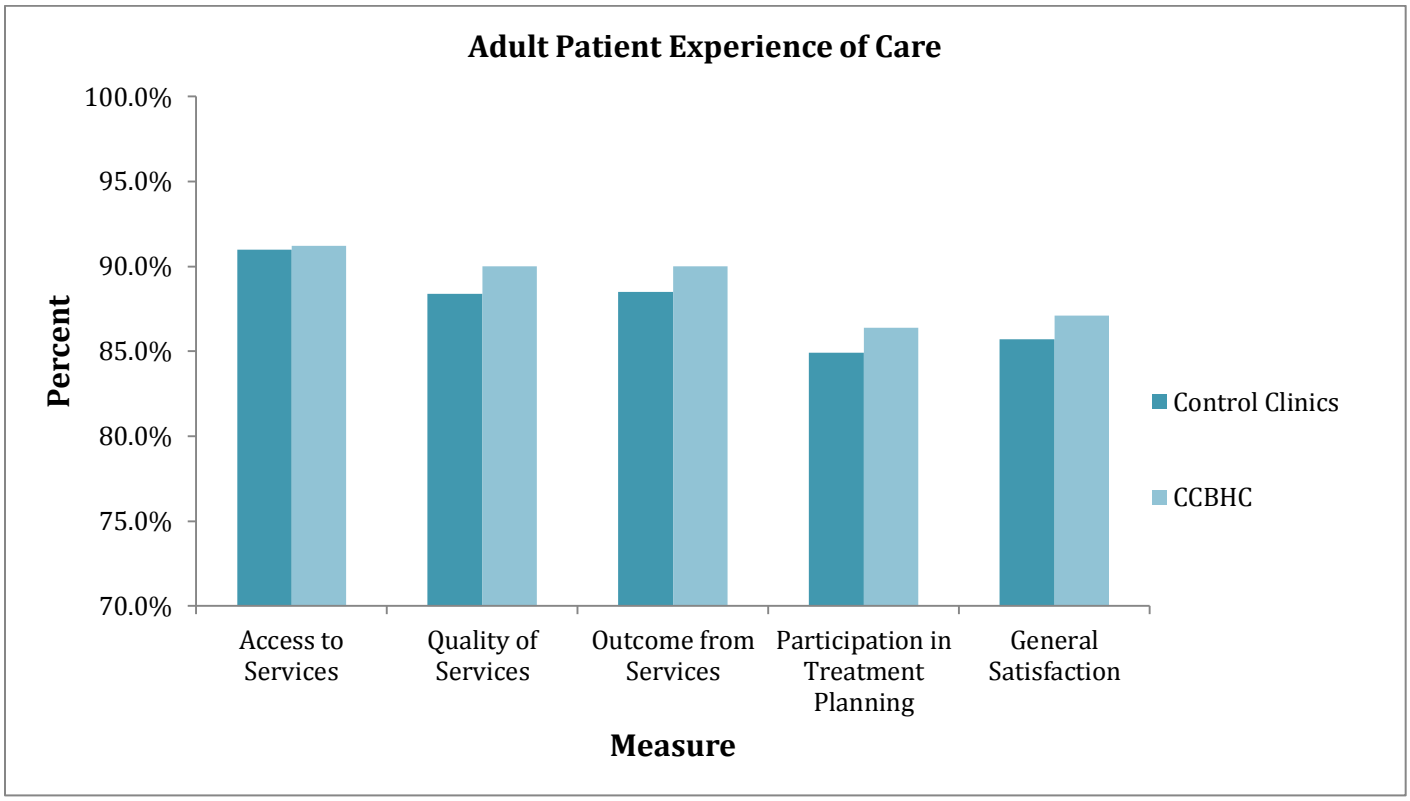

Figure 4.1 Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care

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

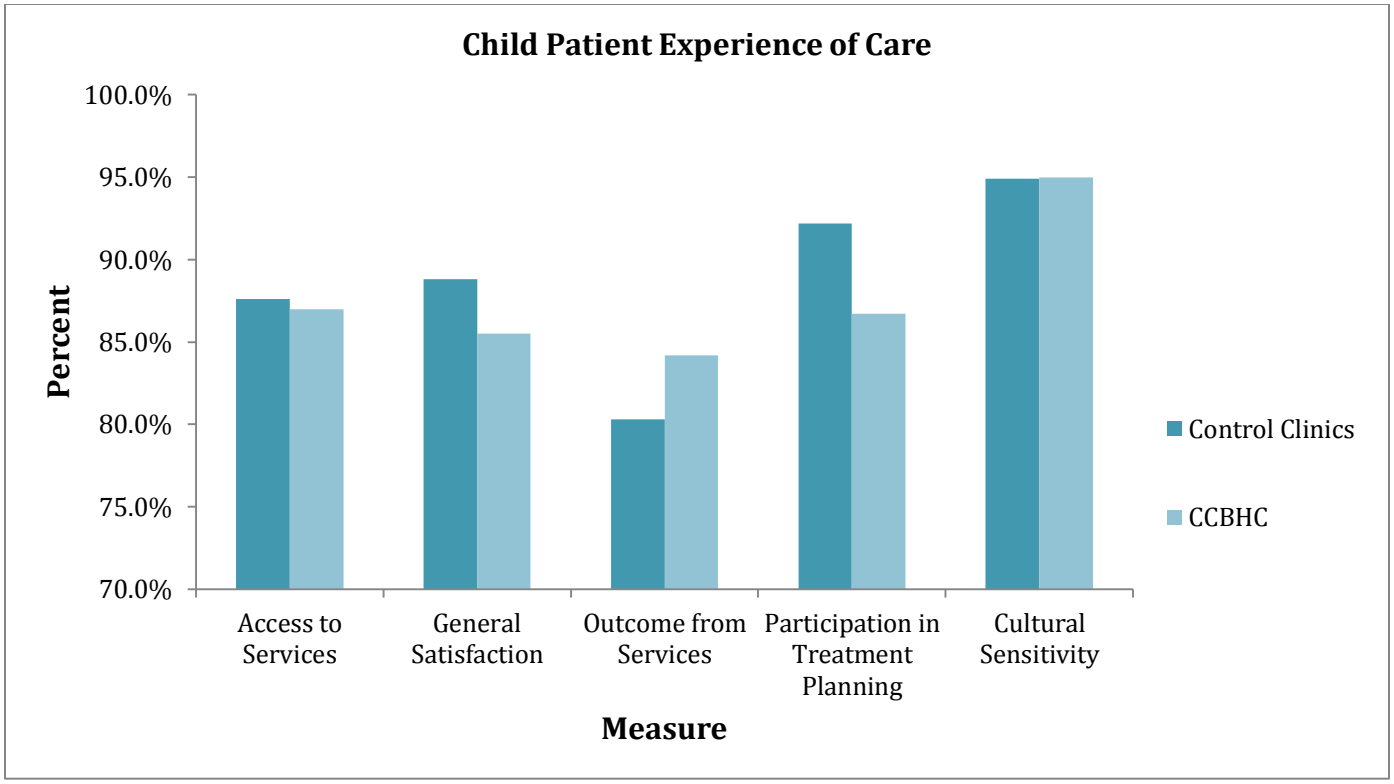

Figure 4.2 Comparison of CCBHC to Control Clinics on Child Patient Experience of Care

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

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

V: 2017 Opportunities for Improvement – MCO Response

Current and Proposed Interventions

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

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

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

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

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

Quality Improvement Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2017, MBH began to address opportunities for improvement related to compliance categories within the following Subparts: C (Enrollee Rights), D (Access to Care, Coordination and Continuity of Care, Coverage and Authorization of Services, Practice Guidelines, and Quality Assessment and Performance Improvement Program), and F (Federal and State Grievance System Standards Regulations). The partially compliant categories within Subpart F were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by MBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring MBH into compliance with the relevant Standards. **Table 5.1** presents MBH's responses to opportunities for improvement cited by IPRO in the 2018 EQR Technical Report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.1: MBH Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
MBH 2018.01	Within Subpart C: Enrollee Rights and Protections Regulations, MBH was partially compliant with one out of seven categories – Enrollee Rights.	Date(s) of follow-up action taken through 6/30/19	**Standard 60, Substandard 2 & 3: 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; 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.** Complaint training curriculum revised based on organizational & functional changes, and in compliance with PS&R Appendix H & Act 68. All staff, including Peer Advisors are trained on the complaint workflows and procedures. In 2016, Magellan Customer Service Associates (CSA) training for Complaints & Grievances took place on 1/13/16; and Care Management (CM) training on Complaints & Grievances took place 2/3/16. In 2017, CM and CSA training for Complaints and Grievances was conducted on 1/18/17. In 2018, in response to the Magellan PEPS CAP item: "Complaints and grievances are two different processes and need to be split into separate training curriculums for MBH staff", unique training sessions were held. Complaint Training was held on 5/2/18 and Grievance Training was held on 5/9/18 for all staff. Following the release of Appendix H of the Program Standards and Requirements, additional trainings for staff and primary contractors were conducted on 8/22/18 (Grievances) and 8/29/18 (Complaints). To address the changes to the Program Standards and Requirements, Appendix H, Magellan hired an additional Compliance Care Manager to the Complaints and Grievances Department, effective 9/10/18.
		Date(s) of future action planned- 7/10/19	In 2019, the annual Complaints Refresher Training was held on 7/10/19.
		Date(s) of future action planned- 7/24/19	In 2019, the annual Grievances Refresher Training was held on 7/24/19.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of future action planned- Ongoing	Customer Service Associates, Physicians and Care Managers will continue to receive Complaints & Grievances training on an annual basis, at a minimum. Peer Representatives, County Staff and other panel members will be trained in the complaint and grievance process in order to serve on the review panels. The Primary Contractors will continue to review all complaint and grievance letters upon receipt. 20% of Complaint and Grievance letters are also audited by the Primary Contractors on a quarterly basis. Magellan will respond to Primary Contractor feedback and adjust procedure as applicable.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
MBH 2018.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, MBH was partially compliant with four out of 10 categories and was non-compliant with one out of 10 categories within Subpart D The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, and 3) Practice Guidelines 4) Quality assessment and performance improvement program The non-compliant category was Coordination and Continuity of Care.	Date(s) of follow-up action taken through 6/30/19	**Standard 28, Substandard 1: Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns:** In order to address deficiencies identified, clinical prompts within Magellan's IP system were updated. Areas addressed include: the need for Denial documentation to reflect that necessary steps are taken to seek additional clinical information to guide denial determinations, including diagnostic information, course of illness, response to treatment, symptom severity, environmental factors, and the availability of appropriate alternative services in the event of a denial and documentation of MNC. The Care Management prompts were updated in May, 2016 to ensure that Care Managers are documenting the specific MNC in clinical notes. The IP prompts were updated in September, 2017 to include/ enhance prompts for Peer Coordination and Family Visits during RTF. In March and June, 2018 IP prompts were added/ updated to support Project Red components into the Concurrent Review process. In February 2019, IP Prompts were updated to include prompts for Provider Performance Inquiry Reviews (PPIRs). In March 2019, IP prompts were updated to support Project Red components into the Concurrent Review process. In June, 2019, IP Prompts were added to address Social Determinants of Health. The comprehensive list of updates to all IP Prompts is embedded here.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action taken through 6/30/19	Trainings on Operational Effectiveness, Clinical Documentation and Active Care Management have been conducted to address clinical reviews demonstrating consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. The 2017 training on Operational Effectiveness took place on 8/2/17. The 2018 Training on Operational Effectiveness was conducted for CMs on 8/1/18.
		Date(s) of follow-up action taken through 6/30/19	Training for clinical team on BHRS level of care Guidelines was conducted on 9/27/17 to ensure adequate clinical information is collected to support determinations.
		Date(s) of follow-up action taken through 6/30/19	Workflow/ Guidelines were created to assist Care Managers in consistent identification and/or referral of clinical/medical quality issues to Physician Advisors.
		Date(s) of follow-up action taken through 6/30/19	The Clinical and Medical Team will educate providers about alternative levels of care during reviews and ensure that the level of care being requested is the least restrictive and medically necessary. This will be documented in IP notes. Magellan has also developed a HealthChoices Level of Care Presentation which will be available on www.MagellanofPA.com for all providers to access. Additionally, all Magellan Clinical Staff were required to take this training by 5/30/18. Care Managers and Medical Team will direct providers to the training during shaping reviews (to address consistent documentation of the consideration of alternatives when 24-hour level of care is requested to ensure the least restrictive medically necessary level of care is considered).

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action taken through 6/30/19	In order to ensure use of Magellan provider performance processes to address problems with providers' clinical judgment, clinical staff are trained annually on the use of PPIRs for clinical judgment issues, such as when a provider refuses to take a member into treatment or fails to respond to CM suggestions and requests. All clinical staff has the ability to file a PPIR in the QI database. In 2016, the training was conducted on 12/7/16. In 2017, the PPIR training took place on 12/6/17. In 2018, the training took place on 5/16/18. To ensure coordination in the management of concerns with providers' performance across Magellan's QI, Clinical, Medical and Network departments, PPIR issues referred to the Provider Quality Advisory Committee (PQAC). Recommendations and suggestions from PQAC are referred to RNCC for possible network action. PPIR trends and findings are also reviewed during the Quality Improvement Committee (QIC) Meeting.
		Date(s) of future action planned- 7/31/19	The 2019 Training on Operational Effectiveness was conducted for CMs on 7/31/19.
		Date(s) of future action planned- Ongoing	CM Training on the Operational Effectiveness is conducted annually.
		Date(s) of future action planned- Ongoing	IP Prompts are monitored ongoing and as opportunities are identified to impact appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns, changes will be made accordingly.
		Date(s) of future action planned- Ongoing	Training for clinical staff on the PPIR process is conducted annually.
		Date(s) of follow-up action taken through 6/30/19	**Standard 28, 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.** In March 2016, Magellan implemented monitoring audits to ensure that the medical necessity decision made by the Physician/ Advisor is supported by documentation in the denial record and reflects the

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			appropriate medical necessity criteria. The findings of the audits are reviewed weekly with the Clinical Department. Denial records are also formally audited on a quarterly basis by the Primary Contractors. The Primary Contractors also review all denial letters. Magellan responds to Primary Contractor feedback and adjusts procedure as applicable. Training for Physician Advisors was conducted on HealthChoices Levels of Care to address documentation of appropriate and available alternative services when issuing a denial.
		Date(s) of follow-up action taken through 6/30/19	Training for clinical and medical team- Operational Effectiveness: Opportunities for Improvement Training was conducted on 8/4/17. The 2018 Training on Operational Effectiveness was conducted on 8/1/18.
		Date(s) of future action planned- 7/31/19	The 2019 Training on Operational Effectiveness was conducted on 7/31/19.
		Date(s) of future action planned- Ongoing	Training on the Operational Effectiveness is conducted annually for all clinical and medical staff.
		Date(s) of future action planned- Ongoing	Denial records are audited on a quarterly basis by all Primary Contractors. The Primary Contractors also review all denial letters. Magellan responds to Primary Contractor feedback and adjusts procedure as applicable.
		Date(s) of follow-up action taken through 6/30/19	**Standard 28, Substandard 3: Other: Significant onsite review findings related to Standard 28** In order to address post-discharge follow-up contact workflows, Magellan developed a comprehensive Follow-Up after Hospitalization (FUH) plan which includes texting technology, provider verification process and provider outreach when a member cannot be contacted. Training for CSRs and Care Managers was conducted to ensure the CSA's and CM's have a clear understanding their roles and responsibilities within the post discharge process.

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Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action taken through 6/30/19	**Standard 23, Substandard 4: BH-MCO shall make services available that ensure effective communication with non-English-speaking populations that include: (a) Oral Interpretation services [Interpreters or telephone interpreter services]; (b) Written Translation services, including member handbooks, consumer satisfaction forms, and other vital documents in the member's primary language (for language groups with 5% or more of the total eligible membership]; (c) Telephone answering procedures that provide access for non-English-speaking members.** Magellan partnered with the interpretation vendor (Pacific Interpreters/ Voiance) to create separate accounts for each of the six PA HealthChoices counties. All counties are logged and identified by a unique billing code for distinct reporting purposes. This work was completed in July 2018 and reportable in August 2018, separately by contract. Interpreter Services C650 monthly report. August report is included here as evidence (please note that Lehigh County is not included because they did not have any calls in August that requested interpreter services).
		Date(s) of follow-up action taken through 6/30/19	**Standard 91, Substandard 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 processes; denial rates; upheld and overturned grievance rates; and treatment outcomes).** In the 2018 third quarter PEPS report, Magellan shared the following updates on Quality Work Plan Indicator #17: • Magellan's CHC Care Manager, who has experience working with the older adult population, joined the Magellan team in April 2018. • Magellan representatives have participated in ongoing CHC meetings with county stakeholders, such as BH, MH, AAA, and Health Departments

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Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			with the goal of sharing information and collaborating on CHC implementation. • Initial workflows were developed and implemented in 2018, based on feedback received from initial collaborative meetings with the CHC MCOs. Highlighted in the workflow are details such as who can be contacted for review, how to find community providers, when a consent is needed, etc. • Care collaboration has been ongoing with all three CHC MCOs. Both Magellan and the CHC MCOs have been identifying members for clinical collaboration efforts. Additional actions and interventions for this Work Plan activity during 2018 included: • Magellan continues to meet with each CHC MCO individually, at least monthly, to discuss coordination efforts, expectations, and clinical/data needs. • Magellan uses claims information to identify members who are active with CHC and who are at higher risk for readmission. These members are then shared with the CHC MCOs, for collaboration and follow up. • Magellan conducts cost monitoring, level of care access monitoring and outreach to Nursing Facilities/Home Health Agencies, and contracting with BH agencies who were already co-located in Nursing Facilities. • The process of finalizing the Letters of Agreement (LOA) for the Southwest Region with each CHC MCO was finalized prior to January 2018, to allow for clinical collaboration. • Two of the three CHC MCOs have asked for claims data, to assist in developing a better understanding of their CHC population. The processes of sharing data and exchange of information will continue to be reviewed for identification of ongoing data needs and for development of a secure data sharing protocol. • Magellan has representatives at each of the CHC regional summits. For the 2019 Work Plan, because the earlier established goals were achieved, as part of the CQI process, Magellan adjusted the Objective for CHC and this is reflected now in the Quality Work Plan (#68): Objective- Magellan will participate in routine

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			meetings to continue implementation and maintenance of the Community HealthChoices program to collaborate, coordinate and share best practices. Goal- Attend regional meetings and maintain ongoing care coordination strategies with providers. The Integrated Care Manager is the individual responsible to annually report progress to the Quality Improvement Committee.
		Date(s) of follow-up action taken through 6/30/19	**<u>Standard 91, Substandard 6: The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.</u>** Magellan strives to be a community contributor and has significant involvement with community-based organizations. Below reflects a sampling of ways in which Magellan has demonstrated collaborative efforts with schools and other organizations. • Magellan routinely supports management of RFI processes to review of proposals and jointly study the need for services in the community. These review groups include many participants that collaborate on the venture, for example, representatives from Magellan, county behavioral health staff, representatives from the office of intellectual and developmental disabilities, juvenile probation, children and youth, etc. • Magellan sponsors training opportunities in the community. While Magellan does often support continuing education credits for clinicians, Magellan also supports robust offerings for the community through involvement with conferences, and trainings to encourage collaboration with other systems partners, such as to local magistrates, school districts, and emergency response teams. Specifically, Magellan has sponsored opportunities for Crisis Intervention Team (CIT) trainings. • More recently, Magellan has increased coordination with county partners to understand the impact of social determinants of health. Magellan invests Project Management resources into county supported projects, such as the "Now Is the Time (NITT): Health Transitions" grant, which is a five year project working to bridge the gap between young adults and adulthood. Goals included housing, a respite program and a LGBTQI initiative (which resulted in a conference). • Magellan serves as a Collaborator in the Reducing

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			the PA Incompetency to Stand Trial Restoration project with Northampton HC, focusing energies on increasing relationships, services and interventions with courts, prison and re-entry services as well as with our law enforcement community. • Magellan has served as a presenter at hospital based Grand Rounds. • Magellan also participates in workgroups focused on identification of community needs for specialty populations, e.g. Sepsis Treatment & Addiction Recovery (STAR) STAR program @ St. Luke's University Health Network (SLUHN), for patients diagnosed with endocarditis. This pilot allows eligible patients to be accepted at local substance abuse rehabilitation after assessment by another provider and receive home health care nursing while in treatment, rather than remain in acute hospital setting. • Magellan was a significant contributor to the Many Aspects of Prevention Summit held in May 2019, which was focused on primary, secondary and tertiary prevention. Community-focused programs included the program within Lehigh County Jail, Center of Excellence for Opioid Use Disorder at Treatment Trends, Lehigh County Blue Guardian, and the Allentown Outreach initiative. The Summit increased training and provider knowledge base surrounding use of MAT, provided an overview of Naloxone to reverse overdose, and use of Trauma Informed Care as a tool for overdose prevention. • Magellan is an active participant in the Northampton County Suicide Prevention Task Force.
		Date(s) of future action planned- 10/24/19	Recommendations for the 2020 Quality Work Plan will be discussed during the QIC meeting on 10/24/19.
		Date(s) of future action planned- Ongoing	Recommendations for the quality Work Plan are noted and moving forward, Magellan enhance the plan to include formalized collaborative efforts with organizations such as schools, state and local police departments, and other organizations.
		Date(s) of follow-up action taken through 6/30/19	**Standard 91, Substandard 10: The QM work plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance-**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			based contracting selected indicator: Mental Health, and Substance Abuse External Quality Review: Follow-up After Mental Health Hospitalization QM Annual Summary Report. To address how Magellan will assess the quality of service and treatment plans: Routine Treatment Record Review (TRR) activities include quality review of individualized service plans and treatment plans, though it is not explicitly described in the Magellan Quality Work Plan (#16) Objective: Monitor documentation practices against policies/procedures; Results shared with providers. However, attached are examples of sections of the MH and SA Tools that assess the quality of service and treatment planning during routine TRR activities, specifically Sections D, Individualized Treatment Plan & Section E, Ongoing Treatment. Each Magellan level of care auditing tool(s) contain a section dedicated to individualized treatment planning/service plans. Magellan's Treatment Record Review tools are aligned with Pennsylvania regulations based on levels of care.
		Date(s) of future action planned- 10/24/19	Recommendations for the 2020 Quality Work Plan will be discussed during the QIC meeting on 10/24/19.
		Date(s) of future action planned- Ongoing	Recommendations for the quality Work Plan are noted and moving forward, Magellan enhance the plan to assess the quality of service and treatment plans in this indicator.
		Date(s) of follow-up action taken through 6/30/19	**Standard 91, Substandard 11: The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.** Annually network providers are surveyed on their experience with Magellan and findings are reported by the Network Team to the Quality Improvement Committee. The survey tool attached below demonstrates that Magellan surveys providers in the following areas of focus in the satisfaction survey including: • Referral Process • Adult Care Management Process • Child Care Management Process

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			• Telephone Contact with Magellan Health • Reimbursement Issues (e.g. claims processing) • Credentialing • Communication • Compared to Other Managed Care Companies • Provider Training • Inquiry if the provider has interest in Magellan providing any specific topics of trainings As referenced above, Magellan reports the results of the annual survey to both Network Strategy Committee and to the QIC, as well as all Primary Contractors. Attached below are the annual reports from 2017 and 2018 to reflect Magellan's Provider Experience Survey results. These reports provide some year over year comparison as it pertains to overall provider satisfaction.
		Date(s) of future action planned- 10/24/19	Recommendations for the 2020 Quality Work Plan will be discussed during the QIC meeting on 10/24/19.
		Date(s) of future action planned- Ongoing	Recommendations for the quality Work Plan are noted and moving forward, Magellan will enhance the plan to add specificity for provider experience and will include areas of survey focus and benchmarks from the previous review period in order to assess progress in the 2020 Work Plan.
		Date(s) of future action planned- 10/24/19	**Standard 91, Substandard 14: The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the annual evaluation and any corrective actions required from previous reviews.** Recommendations for the 2020 Quality Work Plan will be discussed during the QIC meeting on 10/24/19.
		Date(s) of future action planned- Ongoing	The recommendation for the Magellan Quality Work Plan to include information on how previously issues Corrective Action Plans will be addressed is noted. Moving forward, Magellan will enhance the plan to include this information.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
MBH 2018.03	Within Subpart F: Federal and State Grievance System Standards Regulations, MBH was partially compliant with nine out of 10 categories. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions	Date(s) of follow-up action taken through 6/30/19	**Standard 68, Substandard 1: Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process including how the compliant rights and procedures are made known to members, BH-MCO staff and the provider network. 1. BBA Fair Hearing 2. 1st level 3. 2nd level 4.External 5.Expedited;** Complaint script and Customer Contact Form will be updated to include all member rights and an overview of the complaint process. Attestation that member rights were reviewed with the caller will also be added to Customer Contact Form. The script and Customer Contact Form were updated in April, 2018 and then again in September 2018 to align with Appendix H changes. Complaint-specific training will be developed and held on 5/2/18. The curriculum will include the review of the complaint script, need to share all member rights and overview of complaint process at the time of the call, and attestation on the Customer Contact form that this was done. Complaint-specific training incorporating the changes from Appendix H and the updated complaint workflow will be developed and held prior to 9/1/18 expected compliance. Training date was 8/29/18. Complaint workflow to be updated. Complaint from non-member to be initiated on the date of receipt of complaint call. C&G staff will outreach member to discuss complaint and ascertain member's consent and additional detail if complaint is filed by non-member. Acknowledgment to be sent within 5 business days of initial complaint call. Investigation to continue if member is not reached. Decision to be made within 30 days of initial complaint call. All correspondence containing Protected Health Information (PHI) to be sent to member unless member has provided written consent to share PHI with complainant.
		Date(s) of follow-up action taken through 6/30/19	**Standard 68, Substandard 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.**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Complaint-specific training incorporating the changes from Appendix H and which complaint issues are eligible for Fair Hearings will be developed and held prior to 9/1/18 expected compliance. Training date was 8/29/18. Complaint workflow updated. A Complaint from a non-member will be initiated on the date of receipt of complaint call. C&G staff will outreach member to discuss complaint and ascertain member's consent and additional detail if complaint is filed by non-member. Acknowledgment to be sent within 5 business days of initial complaint call. Investigation to continue if member is not reached. Decision to be made within 30 days of initial complaint call. All correspondence containing Protected Health Information (PHI) to be sent to member unless member has provided written consent to share PHI with complainant. Magellan will document in the complaint record if there are extenuating circumstances resulting in delayed correspondence.
		Date(s) of future action planned- 7/10/2019	**Standard 68, Substandards 1 & 2** In 2019, the annual Complaints Refresher Training was held on 7/10/19.
		Date(s) of future action planned- Ongoing	**Standard 68, Substandards 1 & 2** Complaint Training is conducted annually for all clinical and medical staff
		Date(s) of follow-up action taken through 6/30/19	**Standard 68, Substandard 3: Complaint decision letters must be written in clear, simple language that includes each issue identified in the member's complaint and a corresponding explanation and reason for the decision(s)** Complaint workflow to be updated. Initial member interview to be attempted prior to sending the acknowledgment notice to ensure accuracy of complaint and consistency in issues reviewed. Magellan will make 3 attempts to reach the member over 3 business days (all call attempts will be documented). Complaint decision notice will therefore include a determination regarding each issue and correspond with issues as outlined in the acknowledgment notice.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Complaint Investigation and Decision Making Training was developed and held in January, 2019 after finalization of Appendix H. Curriculum emphasized need for committee to identify follow up needs. Follow up specific to support of the member shall be documented in MBH Care Management Notes. Curriculum emphasizes need for case file to reference where documentation can be found if the follow up does not specifically pertain to the member. For supported complaints, a new Substantiated Complaint Follow-up form was developed to ensure follow-up identified by the committee is completed. Decision Letters no longer explain the entire complaint investigation process and only cite the specific resources referenced in the review.
		Date(s) of follow-up action taken through 6/30/19	**Standard 68, Substandard 4: The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.** Complaint Investigation and Decision Making Training was developed and held upon finalization of Appendix H. The curriculum includes requirements of the investigator to document the steps planned, persons to contact and documentation to be requested. Investigator, with support of an Appeals Coordinator, will monitor providers' submission of requested documents and follow up if not provided. Investigator will attempt at minimum an initial interview with member at outset of review and a second interview prior to presentation of complaint to committee. Updated Complaint Review Summary Note clearly identifies the name, credentials, and title of the first level complaint committee member(s) and date of the complaint review. New Decision Summary Note was developed and the date of the Committee Review, participants, documentation considered and follow-up requirements is identified.
		Date(s) of follow-up action taken through 6/30/19	**Standard 68, Substandard 5: Complaint case files must include documentation of any referrals of complaint issues, especially valid complaint issues, to**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			<u>Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the 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.</u> Complaint Investigation and Decision Making Training was developed and held upon finalization of Appendix H. Curriculum emphasizes need for committee to identify follow up needs. Follow up specific to support of the member is documented in MBH Care Management Notes. Curriculum emphasizes the need for case file to reference where documentation can be found if the follow up does not specifically pertain to the member. Substantiated Complaints and any quality of care or compliance concerns identified during complaint reviews are discussed in Member Services Committee and QIC to consider follow-up opportunities. These are also shared as needed during the Provider Quality Advisory Committee (PQAC) and county specific QM monitoring meetings. New Decision Summary Note will be developed and the date of the Committee Review, participants, documentation considered and follow-up requirements will be identified.
		Date(s) of follow-up action taken through 6/30/19	**<u>Standard 71, Substandard 1: Grievances and State Fair Hearings 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.</u>** Grievance script was updated. All rights pertaining to a grievance are fully outlined and shared at the time of the grievance call. Script includes the correct timeframe for sending the acknowledgment notice (3 business days). Script includes requirement to offer translation services when it is identified the member speaks a language other than English, both for the initial call and subsequent discussions and correspondence.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Attestation that member rights were reviewed with the caller was added to Customer Contact Form.
		Date(s) of follow-up action taken through 6/30/19	**Standard 71, Substandard 2: Grievances and State Fair Hearings 100% of grievance acknowledgement and decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.** Grievance-specific training was developed and held on 5/9/18. Curriculum included review of possible outcomes (upheld, overturned, partially overturned) and requirement to use decision template from Appendix H of the PS&R that corresponds with each potential outcome. Curriculum emphasized the need for staff recording grievances to promptly submit grievance requests to Complaint and Grievance team to ensure compliance with correspondence timeframes. Grievance-specific training incorporating the changes from Appendix H and the updated complaint workflow will be developed and held prior to 9/1/18 expected compliance. Training date was 8/22/18. Magellan will document in the grievance record if there are extenuating circumstances resulting in delayed correspondence. The Grievance Workflow was updated.
		Date(s) of follow-up action taken through 7/24/19	**Standard 71, Substandard 2** In 2019, the annual Grievances Refresher Training was held on 7/24/19.
		Date(s) of follow-up action taken through Ongoing	**Standard 71, Substandard 2** Grievance Training is conducted annually for all Magellan clinical and medical staff as well as County staff and other panel members.
		Date(s) of follow-up action taken through 6/30/19	**Standard 71, Substandard 3: Grievances and State Fair Hearings Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2015, RY 2016, and RY 2017 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/19/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			explanation and reason for the decision including the medical necessity criteria utilized. Grievance Templates were updated to align with the language and requirements in Appendix H of the PS&R and NCQA requirements. They were submitted and approved by OMHSAS. Notices will be written in a clear, simple language and include a statement of all services reviewed and a specific explanation and reason for the decision including the MNC used.

Root Cause Analysis and Quality Improvement Plan

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

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

Following several years of underperformance in the key quality indicator areas, OMHSAS determined in 2017 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. In 2017, this change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and corresponding action plans ("CAPs") responding to MY 2015. Instead, BH-MCOs were required to submit member-level files for MY 2016 in the summer of 2017 from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-up After Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and CAP assignments. The change coincided with the coming phase-in of Value-Based Payment (VBP) at the HC BH Contractor level in January 2018. Thus, for the first time, RCA and CAP assignments were made at the Contractor level as well as at the BH-MCO level. Contractors receiving assignments completed their RCAs and CAPs in November 2017, while BH-MCOs completed their RCAs and CAPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and CAP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY2017 performance, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs and CAPs. BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors submitted their RCAs and CAPs by April 30, 2019.

As a result of this shift to a proactive process, MY 2018 goals for FUH All Ages were never set. However, MY 2018 results were calculated in late 2019 to determine RCA and "Quality Improvement Plan" (QIP) assignments, along with goals, for MY2020. In MY 2018, MBH scored below the 75th percentile on both the 7- and 30-day measures and, as a result, completed an RCA and QIP response to address both measures. **Table 5.2** presents MBH's submission of its RCA and QIP

for the FUH 6–64 years 7-day measure, and **Table 5.3** presents MBH's submission of its RCA and QIP for the FUH 6–64 years 30-day measure. Objects embedded within the tables have been removed as exhibits but are available upon request.

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

RCA for MY2018 underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):	***Describe here your overall findings. Please explain the underperformance using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:***
Magellan examined the FUH data by first breaking it down to see if different demographic factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, and race/ ethnicity. Then Magellan examined diagnostic data and attempted to see if any diagnostic categories were associated with higher or lower FUH rates. The analysis included examination of categories of primary diagnoses, as well as comparing FUH rates among populations with and without a secondary substance use disorder diagnosis. Then Magellan sought input on barriers to FUH by surveying inpatient social workers and Magellan members. Their input was incorporated into the list of barriers/causal factors identified in the previous Root Cause Analysis, then adjustments were made to the list of causal factors accordingly. An Ishikawa "fishbone" diagram was constructed to illustrate the causal factors identified in this current Root Cause Analysis (see document "FUH RCA Fishbone"). Magellan decided to combine a few causal factors into a "bundle" of causal factors, because the interventions planned would address the whole bundle and not just each single factor. For example, the previous RCA identified "poor or incomplete discharge plan" as a causal factor of low FUH rates, but the current RCA also identified an opportunity to improve how Social Determinants of Health (SDoH) are identified and addressed during the discharge process. Magellan decided to add this as a piece or "sub-factor" to the causal factor "bundle" of "inadequate discharge planning," since identification of SDoH factors that could impact follow-up, and planning for them, should be part of effective, comprehensive discharge planning. Each identified causal factor was discussed, and the level of actionability was determined taking into account Magellan's previous and current interventions, as well as ideas and suggestions about newly identified or newly refined causal factors. Please see the attachment "RCA 7-day FUH" for details and results of this analysis.	[Objects removed]
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***

People (1) *(e.g., personnel, patients)* ***Co-Occurring Disorders (COD)*** • ***Substance use relapse*** • ***Substance Use Disorder (SUD) not sufficiently addressed***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Because this factor can independently impact FUH rates and can also interact with other factors to impact FUH rates, the causal role is significant. The causal weight for this factor is critical, considering the quantitative (FUH rates for people with co-occurring disorders) and qualitative findings (member and provider opinions). ***Current and expected actionability:*** High Magellan sees multiple opportunities to continue and enhance existing interventions targeting this factor.
People (2) *(e.g., personnel, patients)* ***Stigma & Fear*** • ***Embarrassment about seeking treatment*** • ***Fear of hospitalization or involuntary treatment***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal weight for this factor is somewhat important for the members affected by this factor, even though much has been done by Magellan, providers, and advocacy organizations to reduce stigma and fear. The causal role of this factor is likely less significant that it had been in the past but it's still present. ***Current and expected actionability:*** Moderate Magellan can continue education efforts to members and to people in the community about reducing stigma around mental illnesses and substance use disorders, and about what does and doesn't lead to involuntary treatment.
People (3) *(e.g., personnel, patients)* ***Member chooses to not pursue treatment*** • ***Past negative experiences with treatment*** • ***Believe they do not need treatment***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because if someone is not far enough along in the stages of recovery, or if they have minimal insight about their illness then, in their view, they do not need treatment. Also, past negative experiences with treatment can cause trauma, and result in avoidance of similar situations in the future. ***Current and expected actionability:*** Moderate Magellan views this as an area of continuing opportunity, because trauma-informed care and treatment approaches that include Motivational Interviewing can certainly impact this barrier.
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
Providers (1) *(e.g. provider facilities, provider network)* ***Inadequate Discharge Planning*** • ***Not enough Member input into discharge plan*** • ***Appointment made at a time Member can't attend (too early, conflicts with work/school)*** • ***No clear plan for obtaining medications***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor in general, as well as the examples in the bullet points, has a significant causal role in lower FUH rates. The causal weight of this factor is critical, as inadequate discharge planning, especially when discharge plans do not address all barriers to treatment, is likely to result in lower FUH rates, as well as higher readmission rates.

• ***Social Determinants of Health (SDoH) barriers not identified and addressed sufficiently in discharge planning process***	***Current and expected actionability:*** High Magellan views this as a critical area of continuing opportunity for action. Magellan's existing interventions focused on this factor can be further enhanced by "raising the bar" on inpatient providers, as well as on Magellan's own care management team, to continue to incorporate Project RED informed discharge planning components.
Providers (2) *(e.g. provider facilities, provider network)* ***Inadequate identification of who is at higher risk of not attending follow-up care***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor interacts with other factors to contribute to lower FUH rates. Providers and Magellan frequently talk about factors that increase a person's risk of not following up with aftercare and of readmitting to a hospital; but, without a systematized way of identifying when these factors are present, the level of risk can be missed or underestimated. The causal weight of this factor is important.
	Current and expected actionability: Moderate Magellan can take multiple actions to address this factor. Magellan can assist providers in identifying who may be at risk of not following up with aftercare, and can also take steps to ensure that more of those who are at higher risk are referred to enhanced services.
Policies / Procedures (1) *(e.g., data systems, delivery systems, payment/reimbursement)* ***Open Access*** • ***Some outpatient providers will only offer open-access*** • ***Some outpatient providers will provide a time for an early morning appointment, but it turns out to be open access***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Despite Magellan's recent attempts to emphasize the need for appointments with a date and time for people coming out of 24-hour care, reports come from inpatient providers stating that outpatient providers are only offering "open access" to hospital discharges. Magellan is now also learning that, in many cases, outpatient providers offer an "appointment" for a day and time, usually an early morning, but then the members gets there, and they learn that it's actually an open-access setup. Because this practice seems to be limited to certain outpatient providers, the causal weight may only be "somewhat important." But, it is also noted that the outpatient providers that are continuing this open-access practice tend to be the larger providers in a geographic area.
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
	Current and expected actionability: High Magellan views this as an actionable issue, and has planned multiple ways to identify, track, and respond to this issue.
Policies / Procedures (2) *(e.g., data systems, delivery systems, payment/reimbursement)* ***Outpatient Provider Accessibility*** • ***Lack of timely response to calls/referrals from inpatient providers*** • ***Lack of timely response to calls from members*** • ***Lack of PM and weekend appointments for intake***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor can both directly affect FUH rates, as well as indirectly affect them, by combining with other factors. The shortage of psychiatrists and psychiatrist time was previously identified as somewhat important in the previous RCA. But when combined with other accessibility issues, like a lack of timely response to consumers and referral sources, the causal weight is increased.
• ***Lack of psychiatrist time***	***Current and expected actionability:*** High (except for prescriber time) While the shortage of psychiatrists and other prescribers is more difficult to impact, the responsiveness of outpatient providers and the availability of afternoon, evening, and Saturday appointments present a clear and actionable opportunity for improvement. These are things the provider agencies do have control over.

Provisions (1) *(e.g., screening tools, medical record forms, transportation)* ***Lack of Transportation***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor is significant, and it can directly contribute to lower FUH rates. This barrier was identified by both members and providers as being significant. The causal weight of this factor was recognized in the last RCA as significant/important, and this continues.
	Current and expected actionability: Low While providers and Magellan cannot directly impact transportation challenges, it can indirectly make an impact on this barrier. Although the actionability is low, it is possible to assist inpatient providers with information on transportation services which can help them to make necessary referrals earlier in the hospital stay. This causal factor may have low actionability, but it is so significant that even modest interventions must be attempted.

Quality Improvement Plan for CY 2020

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

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

Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Co-Occurring Disorders • ***Substance use relapse*** • ***SUD not sufficiently addressed***	Ensure that there is discussion of co-occurring disorders during calls about hospital discharge. Ensure that hospital and CM identify that having a secondary SUD diagnosis may lead to higher risk of not attending FUH and that this is addressed in the discharge plan. Magellan QI team and	Add audit item March 2020 Monthly audits are ongoing. Plan to create tool by end of June 2020	Monthly audits of a sample of discharge notes are already conducted, but an item about planning for COD will be added to the audit. Results of the monthly audits will be shared with the clinical team that manages inpatient care, and education/support will be provided on at least a monthly basis. Tracking of new referrals to Specialty Care Management services such as Intensive Care coordination (ICC), Substance Use Comprehensive Care Management (D&A CCM), and Recovery Service

	Clinical team will collaborate with inpatient providers on creating a tool to help identify who is at higher risk of not attending FUH appointments and therefore at higher risk of readmission, based on individual past history, clinical factors and demographic factors. This will help identify who may benefit from Specialty Care Management.		Navigators (RSN) will help monitor whether this intervention is being used (a process measure).
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Stigma & Fear • ***Embarrassment about seeking treatment*** • ***Fear of hospitalization or involuntary treatment***	Will have presentations in 2020 Member Advisory Work Groups (MAWGs) about involuntary treatment and how a member might best prevent this from happening.	MAWG meetings are held twice per year each in Bucks, Cambria, Delaware, and Montgomery Counties, while Lehigh and Northampton have a shared MAWG meeting twice per year. 2020 dates to be determined.	Presentations will take place in MAWG meetings through 2020. Record of these presentations/discussions will be kept and reviewed in Magellan's Member Services Committee.
Member chooses to not pursue treatment • ***Past negative experiences with treatment*** • ***Believe they do not need treatment***	Advocate for providers to integrate Trauma Informed Care (TIC) principles into not only clinical services but also into "customer service" efforts. Magellan QI team is initiating a project to assess "front end customer service" of outpatient clinics and to identify areas for improvement. Advocate for providers to use and train employees on Motivational	Ongoing Customer service assessment project is expected to be completed in Q3 2020.	Magellan will track its communication to providers (via newsletters, website, etc.) about TIC. Magellan team members will telephonically interview OP providers and assess factors like time to call pick-up, time to return call after leaving a message, politeness/professionalism of staff who answer phones, and the helpfulness of information provided to questions that would be common for members to ask. Data will be collected and analyzed, and opportunities for improvement will be identified. Opportunities will be addressed with individual providers, and issues that trend as more common will be addressed more widely, via provider education. Will include questions about training in Motivational Interviewing and Stages of Change in a 2020 provider survey, in order to assess needs.

	Interviewing principles, along with stages of change, including how best to work with individuals who are at different stages regarding recognizing their need for treatment.		
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Inadequate Discharge Planning • ***Not enough Member input into discharge plan*** • ***Appointment made at a time Member can't attend (too early, conflicts with work/school)*** • ***No clear plan for obtaining medications*** • ***SDoH barriers not identified and addressed sufficiently in discharge planning process***	Continue and enhance *Best Practices in Discharge Planning* initiative: • Continue to educate providers on Project RED informed discharge planning, which includes member collaboration about FUH care, times/ days/locations of FUH appointments, plans for obtaining medications, and which requires that SDoH barriers be identified and addressed (if they cannot be resolved, at least planned for). • Continue to monitor Project RED adherence among Care Managers and hospitals, and continually increase expectations around Project RED informed components • Provide education to hospitals based on Magellan's Best Practices in Behavioral Health Discharge Planning • Expand Texting	Ongoing Monthly tracking ongoing Ongoing Began December 18, 2019 and ongoing Tracking began September 2019 and continues through 2020	This effort is discussed in weekly meetings involving inpatient CM team, QI team, System Transformation, and other Magellan management. Audits of Project RED adherence are conducted monthly and reported to inpatient CM team. Education/support will be provided on at least a monthly basis by QI and more frequently by Clinical Supervisors. Audit scores and trends will continue to be tracked monthly. Records will be kept for each educational contact that occurs with hospitals. Timeliness of discharges is tracked and reported weekly. Data on texting initiative (successful texts that went out, reasons why not) is tracked and reported monthly.

	initiative by increasing the numbers of members who consent to text reminders, and		
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
	ensuring that hospitals report discharges in a timely manner so that texts can be sent to members. • Created educational flyer for members about the texting initiative • Shifted to discharge-focused UM process effective January 20, 2020, shaping inpatient concurrent review calls to prioritize discharges and to include discussion of discharge plans at every review.	Flyer published February 2020 New process began January 20, 2020	Successes and challenges of this new process are discussed in weekly meetings involving inpatient CM team, QI team, System Transformation, and other Magellan management.
Inadequate identification of who is at higher risk of not attending follow-up care	Magellan QI team and Clinical team will collaborate with inpatient providers on creating a tool to help identify who is at higher risk of not attending FUH appointments and therefore at higher risk of readmission, based on individual past history, clinical factors and demographic factors. Ensure CMs are sharing the minimum necessary treatment information with hospital SWs that is relevant to the risk of not attending FUH.	Plan to create tool by end of June 2020 Ongoing	Tool will be drafted, tested, and then its implementation and use of will be monitored in routine clinical meetings, to ensure it is being used to help identify cases in which the member may be at higher risk of not attending FUH. Tracking of new referrals to Specialty Care Management services such as Intensive Care Coordination (ICC), Substance Use Comprehensive Care Management (D&A CCM), and Recovery Service Navigators (RSN) will help monitor whether this intervention is being used (a process measure). Revisit in clinical meetings whether CMs understand what they are allowed to share with hospitals, including current case management services that may be in place.

Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Open Access • ***Some outpatient providers will only offer open-access*** • ***Some outpatient providers will provide a time for an early morning appointment, but it turns out to be open access***	Will monitor and track instances of outpatient providers only offering walk-in services to members coming out of 24-hour care, using Magellan's existing system for reporting and tracking provider performance issues. Magellan QI team will provide monthly data on this, by provider, to county partners and providers. Magellan will offer technical assistance as needed to providers.	Magellan work group began to revise the system for reporting and tracking concerns about providers in October 2019 and continues to meet routinely.	The assigned work group anticipates having the revamped process by July 1, 2020. Magellan maintains an interim reporting and tracking process. Magellan will keep records on which providers ask for assistance and what types of assistance is provided. The expected result will be a decrease in reported performance concerns related to open access.
Outpatient Provider Accessibility • ***Lack of timely response to calls/ referrals from inpatient providers*** • ***Lack of timely response to calls from members*** • ***Lack of PM and weekend appointments for intake*** • ***Lack of psychiatrist time***	Will monitor and track instances of problems reaching Outpatient providers (no answer, no timely call back), using Magellan's existing system for reporting and tracking provider performance issues. Magellan QI team will provide monthly data on this, by provider, to county partners and providers. Magellan will encourage Outpatient providers to offer afternoon, evening, and weekend appointments for intakes, at least on a limited basis, via provider newsletter, Provider Quality Assurance	Tracking to begin March 2020 and ongoing. Communication to begin March 2020	The assigned work group anticipates having the revamped process for tracking concerns about providers by July 1, 2020. Magellan maintains an interim reporting and tracking process. Data on which providers offer these times will be tracked in discharge planning calls. Also, questions on PM and Saturday intakes will be include in the front-end customer service project (see below).

Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
	Committee, Value-Based Purchasing meetings, and other communication with providers. Magellan QI team is initiating a project to assess "front end customer service" of outpatient clinics and to identify areas for improvement.	Customer service assessment project is expected to be completed in Q3 2020.	Magellan team members will telephonically interview OP providers and assess factors like time to call pick up, time to return call after leaving a message, politeness/professionalism of staff who answer phones, and the helpfulness of information provided to questions that would be common for members to ask. Data will be collected and analyzed, and opportunities for improvement will be identified. Opportunities will be addressed with individual providers, and issues that trend as more common will be addressed more widely, via provider education.
Lack of Transportation	Magellan will provide guidance to inpatient providers on how to access Medical Assistance Transportation Programs (MATP) in each PA county and encourage that they initiate applications early in the discharge planning process. Magellan will explore transportation options that are available in contracted counties, to ensure that all opportunities for transportation are being utilized.	Will distribute guidance materials by end of June 2020 Began February 2020 and ongoing	Will survey inpatient providers again in Q3 2020, to ask how often they have used the materials on MATP, what was and wasn't helpful, and what barriers still exist. Ongoing monitoring of 7-day and 30-day FUH rates, according to both HEDIS and PA criteria, will reveal if this effort is having any effect on keeping FUH appointments.

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

RCA for MY2018 underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): Magellan examined the FUH data by first breaking it down to see if different demographic factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, and race/ethnicity. Then Magellan examined diagnostic data and attempted to see if any diagnostic categories were associated with higher or lower FUH rates. The analysis included examination of categories of primary diagnoses, as well as comparing FUH rates among populations with and without a secondary substance use disorder diagnosis. Then Magellan sought input on barriers to FUH by surveying inpatient social workers and Magellan members. Their input was incorporated into the list of barriers/causal factors identified in the previous Root Cause Analysis, then adjustments were made to the list of causal factors accordingly. An Ishikawa "fishbone" diagram was constructed to illustrate the causal factors identified in this current Root Cause Analysis (see document "FUH RCA Fishbone"). Magellan decided to combine a few causal factors into a "bundle" of causal factors, because the interventions planned would address the whole bundle and not just each single factor. For example, the previous RCA identified "poor or incomplete discharge plan" as a causal factor of low FUH rates, but the current RCA also identified an opportunity to improve how Social Determinants of Health (SDoH) are identified and addressed during the discharge process. Magellan decided to add this as a piece or "sub-factor" to the causal factor "bundle" of "inadequate discharge planning," since identification of SDoH factors that could impact follow-up, and planning for them, should be part of effective, comprehensive discharge planning. Each identified causal factor was discussed, and the level of actionability was determined taking into account Magellan's previous and current interventions, as well as ideas and suggestions about newly identified or newly refined causal factors. Please see the attachment "RCA 30-day FUH" for details and results of this analysis.	***Describe here your overall findings. Please explain the underperformance using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** [Objects removed]
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
People (1) *(e.g., personnel, patients)* ***Co-Occurring Disorders (COD)***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Because this factor can independently impact FUH rates and can also

• ***Substance use relapse*** • ***Substance Use Disorder (SUD) not sufficiently addressed***	interact with other factors to impact FUH rates, the causal role is significant. The causal weight for this factor is critical, considering the quantitative (FUH rates for people with co-occurring disorders) and qualitative findings (member and provider opinions). ***Current and expected actionability:*** High Magellan sees multiple opportunities to continue and to enhance existing interventions targeting this factor.
People (2) *(e.g., personnel, patients)* ***Stigma & Fear*** • ***Embarrassment about seeking treatment*** • ***Fear of hospitalization or involuntary treatment***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal weight for this factor is somewhat important for the members affected by this factor, even though much has been done by Magellan, providers, and advocacy organizations to reduce stigma and fear. The causal role of this factor is likely less significant than it had been in the past but it's still present. ***Current and expected actionability:*** Moderate Magellan can continue education efforts to members and to people in the community about reducing stigma around mental illnesses and substance use disorders, and about what does and doesn't lead to involuntary treatment.
People (3) *(e.g., personnel, patients)* ***Member chooses to not pursue treatment*** • ***Past negative experiences with treatment*** • ***Believe they do not need treatment***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because if someone is not far enough along in the stages of recovery, or if they have minimal insight about their illness then, in their view, they do not need treatment. Also, past negative experiences with treatment can cause trauma, and result in avoidance of similar situations in the future. ***Current and expected actionability:*** Moderate Magellan views this as an area of continuing opportunity, because trauma-informed care and treatment approaches that include Motivational Interviewing can certainly impact this barrier.
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
Providers (1) *(e.g. provider facilities, provider network)* ***Inadequate Discharge Planning*** • ***Not enough Member input into discharge plan*** • ***Appointment made at a time Member can't attend (too early, conflicts with work/school)*** • ***No clear plan for obtaining medications*** • ***Social Determinants of Health (SDoH) barriers not identified and addressed sufficiently in discharge planning process***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor in general, as well as the examples in the bullet points, has a significant causal role in lower FUH rates. The causal weight of this factor is critical, as inadequate discharge planning, especially when discharge plans do not address all barriers to treatment, is likely to result in lower FUH rates, as well as higher readmission rates. ***Current and expected actionability:*** High Magellan views this as a critical area of continuing opportunity for action. Magellan's existing interventions focused on this factor and can be further enhanced by "raising the bar" on inpatient providers, as well as on Magellan's own care management team, to continue to incorporate

	Project RED informed discharge planning components.
Providers (2) *(e.g. provider facilities, provider network)* ***Inadequate identification of who is at higher risk of not attending follow-up care***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor interacts with other factors to contribute to lower FUH rates. Providers and Magellan frequently talk about factors that increase a person's risk of not following up with aftercare and of readmitting to a hospital, but without a systematized way of identifying when these factors are present, the level of risk can be missed or underestimated. The causal weight of this factor is important.
	Current and expected actionability: Moderate Magellan can take multiple actions to address this factor. Magellan can assist providers in identifying who may be at risk of not following up with aftercare, and can also take steps to ensure that more of those who are at higher risk are referred to enhanced services.
Policies / Procedures (1) *(e.g., data systems, delivery systems, payment/reimbursement)* ***Open Access*** • ***Some outpatient providers will only offer open-access*** • ***Some outpatient providers will provide a time for an early morning appointment, but it turns out to be open access***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Despite Magellan's recent attempts to emphasize the need for appointments with a date and time for people coming out of 24-hour care, reports come from inpatient providers stating that outpatient providers are only offering "open access" to hospital discharges. Magellan is now also learning that, in many cases, outpatient providers offer an "appointment" for a day and time, usually an early morning, but then the members gets there and learns that it's actually an open-access setup. Because this practice seems to be limited to certain outpatient providers, the causal weight may only be "somewhat important." But, it is also noted that the outpatient providers that are continuing this open-access practice tend to be the larger providers in a geographic area.
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
	Current and expected actionability: High Magellan views this as an actionable issue, and has planned multiple ways to identify, track, and respond to this issue.
Policies / Procedures (2) *(e.g., data systems, delivery systems, payment/reimbursement)* ***Outpatient Provider Accessibility*** • ***Lack of timely response to calls/referrals from inpatient providers*** • ***Lack of timely response to calls from members*** • ***Lack of PM and weekend appointments for intake*** • ***Lack of psychiatrist time***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor can both directly affect FUH rates, as well as indirectly affect them, by combining with other factors. The shortage of psychiatrists and psychiatrist time was previously identified as somewhat important in the previous RCA. But, when combined with other accessibility issues, like a lack of timely response to consumers and referral sources, the causal weight is increased.
	Current and expected actionability: High (except for prescriber time) While the shortage of psychiatrists and other prescribers is more difficult to impact, the responsiveness of outpatient providers and the availability of afternoon, evening, and Saturday appointments present a clear and actionable opportunity for improvement. These are things the provider agencies do have control over.
Provisions (1)	***Causal Role (relationship to other factors and to the overall performance***

(e.g., screening tools, medical record forms, transportation) ***Lack of Transportation***	***indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor is significant, and it can directly contribute to lower FUH rates. This barrier was identified by both members and providers as being significant. The causal weight of this factor was recognized in the last RCA as significant/important, and this continues.
	Current and expected actionability: Low While providers and Magellan cannot directly impact transportation challenges, it can indirectly make an impact on this barrier. Although the actionability is low, it is possible to assist inpatient providers with information on transportation services that can help them to make necessary referrals earlier in the hospital stay. This causal factor may have low actionability, but it is so significant that even modest interventions must be attempted.

Quality Improvement Plan for CY 2020

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

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

Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Co-Occurring Disorders • ***Substance use relapse*** • ***SUD not sufficiently addressed***	Ensure that there is discussion of co-occurring disorders during calls about hospital discharge. Ensure that hospital and CM identify that having a secondary SUD diagnosis may lead to higher risk of not attending FUH and that this is addressed in the discharge plan Magellan QI team and Clinical team will collaborate with inpatient providers on creating a tool to help	Add audit item March 2020 Monthly audits are ongoing. Plan to create tool by end of June 2020	Monthly audits of a sample of discharge notes are already conducted, but an item about planning for COD will be added to the audit. Results of the monthly audits will be shared with the clinical team that manages inpatient care, and education/support will be provided on at least a monthly basis. Tracking of new referrals to Specialty Care Management services such as Intensive Care coordination (ICC), Substance Use Comprehensive Care Management (D&A CCM), and Recovery Service Navigators (RSN) will help monitor whether this intervention is being used (a process measure).

	identify who is at higher risk of not attending FUH appointments and therefore at higher risk of readmission, based on individual past history, clinical factors and demographic factors. This will help identify who may benefit from Specialty Care Management.		
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing,Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Stigma & Fear • ***Embarrassment about seeking treatment*** • ***Fear of hospitalization or involuntary treatment***	Will have presentations in 2020 Member Advisory Work Groups (MAWGs) about involuntary treatment and how a member might best prevent this from happening.	MAWG meetings are held twice per year each in Bucks, Cambria, Delaware, and Montgomery Counties, while Lehigh and Northampton have a shared MAWG meeting twice per year. 2020 dates to be determined.	Presentations will take place in MAWG meetings through 2020. Record of these presentations/discussions will be kept and reviewed in Magellan's Member Services Committee.
Member chooses to not pursue treatment • ***Past negative experiences with treatment*** • ***Believe they do not need treatment***	Advocate for providers to integrate Trauma Informed Care (TIC) principles into not only clinical services but into "customer service" efforts. Magellan QI team is initiating a project to assess "front end customer service" of outpatient clinics and identify areas for improvement. Advocate for providers to use and train employees on Motivational Interviewing principles	Ongoing Customer service assessment project is expected to be completed in Q3 2020.	Magellan will track its communication to providers (via newsletters, website, etc.) about TIC. Magellan team members will telephonically interview OP providers and assess factors like time to call pick up, time to return call after leaving a message, politeness/professionalism of staff who answer phones, and the helpfulness of information provided to questions that would be common for members to ask. Data will be collected and analyzed, and opportunities for improvement will be identified. Opportunities will be addressed with individual providers, and issues that trend as more common will be addressed more widely, via provider education. Will include questions about training in Motivational Interviewing and Stages of Change in a 2020 provider survey, in order to assess needs.

	along with stages of change, including how best to work with individuals who are at different stages regarding recognizing their need for treatment.		
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g.,Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Inadequate Discharge Planning • ***Not enough Member input into discharge plan*** • ***Appointment made at a time Member can't attend (too early, conflicts with work/ school)*** • ***No clear plan for obtaining medications*** • ***SDoH barriers not identified and addressed sufficiently in discharge planning process***	Continue and enhance *Best Practices in Discharge Planning* initiative: • Continue to educate providers on Project RED informed discharge planning, which includes member collaboration about FUH care, times/days/locations of FUH appointments, plans for obtaining medications, and which requires that SDoH barriers be identified and addressed (if they cannot be resolved, at least planned for). • Continue to monitor Project RED adherence among Care Managers and hospitals, and continually increase expectations around Project RED informed components • Provide education to hospitals based on Magellan's Best Practices in Behavioral Health Discharge Planning • Expand Texting initiative by increasing the numbers of	Ongoing Monthly tracking ongoing Ongoing Began December 18, 2019 and ongoing	This effort is discussed in weekly meetings involving inpatient CM team, QI team, System Transformation, and other Magellan management. Audits of Project RED adherence are conducted monthly and reported to inpatient CM team. Education/support will be provided on at least a monthly basis by QI and more frequently by Clinical Supervisors. Audit scores and trends will continue to be tracked monthly. Records will be kept for each educational contact that occurs with hospitals.

	members who consent to text reminders, and ensuring that hospitals report discharges in a timely		
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
	manner so that texts can be sent to members. • Created educational flyer for members about the texting initiative • Shifted to discharge-focused UM process effective January 20, 2020, shaping inpatient concurrent review calls to prioritize discharges and to include discussion of discharge plans at every review.	Tracking began September 2019 and continues through 2020 Flyer published February 2020 New process began January 20, 2020	Timeliness of discharges is tracked and reported weekly. Data on texting initiative (successful texts that went out, reasons why not) is tracked and reported monthly. Successes and challenges of this new process are discussed in weekly meetings involving inpatient CM team, QI team, System Transformation, and other Magellan management.
Inadequate identification of who is at higher risk of not attending follow-up care	Magellan QI team and Clinical team will collaborate with inpatient providers on creating a tool to help identify who is at higher risk of not attending FUH appointments and therefore at higher risk of readmission, based on individual past history, clinical factors and demographic factors. Ensure CMs are sharing the minimum necessary treatment information with hospital SWs that is relevant to the risk of not attending FUH.	Plan to create tool by end of June 2020. Ongoing	Tool will be drafted, tested, and then the implementation and use of the tool will be monitored in routine clinical meetings, to ensure it is being used to help identify cases in which the member may be at higher risk of not attending FUH. Tracking of new referrals to Specialty Care Management services such as Intensive Care Coordination (ICC), Substance Use Comprehensive Care Management (D&A CCM), and Recovery Service Navigators (RSN) will help monitor whether this intervention is being used (a process measure). Revisit in clinical meetings whether CMs understand what they are allowed to share with hospitals, including current case management services that may be in place.
Barrier	***Action*** *Include those*	***Implementation***	***Monitoring Plan***

	planned as well as already implemented.	***Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	*How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Open Access • ***Some outpatient providers will only offer open-access.*** • ***Some outpatient providers will provide a time for an early morning appointment; but, it turns out to be open access***	Will monitor and track instances of outpatient providers only offering walk-in services to members coming out of 24-hour care, using Magellan's existing system for reporting and tracking provider performance issues. Magellan's QI team will provide monthly data on this, by provider, to county partners and providers. Magellan will offer technical assistance as needed to providers.	Magellan's work group began to revise the system for reporting and tracking concerns about providers in October 2019 and continues to meet routinely.	The assigned work group anticipates having the revamped process by July 1, 2020. Magellan maintains an interim reporting and tracking process. Magellan will keep records on which providers ask for assistance and what types of assistance is provided. The expected result will be a decrease in reported performance concerns related to open access.
Outpatient Provider Accessibility • ***Lack of timely response to calls/referrals from inpatient providers*** • ***Lack of timely response to calls from members*** • ***Lack of PM and weekend appointments for intakes*** • ***Lack of psychiatrist time***	Will monitor and track instances of problems reaching Outpatient providers (no answer, no timely call back), using Magellan's existing system for reporting and tracking provider performance issues. Magellan QI team will provide monthly data on this, by provider, to county partners and providers. Magellan will encourage Outpatient providers to offer afternoon, evening, and weekend appointments for intakes, at least on a limited basis, via provider newsletter, Provider Quality Assurance	Tracking to begin March 2020 and ongoing. Communication to begin March 2020	The assigned work group anticipates having the revamped process for tracking concerns about providers by July 1, 2020. Magellan maintains an interim reporting and tracking process. Data on which providers offer these times will be tracked in discharge planning calls. Also, questions on PM and Saturday intakes will be include in the front-end customer service project (see below).
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing,*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*

		Quarterly)	
	Committee, Value-Based Purchasing meetings, and other communication with providers. Magellan's QI team is initiating a project to assess "front end customer service" of outpatient clinics and identify areas for improvement.	Customer service assessment project is expected to be completed in Q3 2020.	Magellan team members will telephonically interview OP providers and assess factors like time to call pick up, time to return call after leaving a message, politeness/professionalism of staff who answer phones, and the helpfulness of information provided to questions that would be common for members to ask. Data will be collected and analyzed, and opportunities for improvement will be identified. Opportunities will be addressed with individual providers, and issues that trend as more common will be addressed more widely, via provider education.
Lack of Transportation	Magellan will provide guidance to inpatient providers on how to access Medical Assistance Transportation Programs (MATP) in each PA county and encourage that they initiate applications early in the discharge planning process. Magellan will explore transportation options that are available in contracted counties, to ensure that all opportunities for transportation are being utilized.	Will distribute guidance materials by end of June 2020. Began February 2020 and ongoing.	Will survey inpatient providers again in Q3 2020, to ask how often they have used the materials on MATP, what was and wasn't helpful, and what barriers still exist. Ongoing monitoring of 7-day and 30-day FUH rates, according to both HEDIS and PA criteria, will reveal if this effort is having any effect on keeping FUH appointments.

VI: 2019 Strengths and Opportunities for Improvement

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

Strengths

- MBH's HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness MY 2018 rates (QI 1 and QI 2) for the 18-64 and 6+ years age groups improved significantly from MY 2017.
- MBH's HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness MY 2018 rates (QI 1 and QI 2) for the 6-17 years age set was significantly above the corresponding Statewide HealthChoices rates.
- MBH's PA-specific 7- and 30-Day Follow-up After Hospitalization for Mental Illness MY 2018 rates (QI 1 and QI 2) for the 6-17 years age set was significantly above the corresponding Statewide HealthChoices rates.
- MBH's PA-specific 7- and 30-Day Follow-up After Hospitalization for Mental Illness MY 2018 rates (QI A and QI B) improved significantly from MY 2017, reversing years of decline.
- MBH's MY 2018 Initiation of AOD Treatment rates for ages 18+ and All Ages (ages 13+) were statistically significantly higher (better) than the prior year.
- MBH's MY 2018 Engagement of AOD Treatment performance rate for all age cuts did achieve the goal of meeting or exceeding the HEDIS Quality Compass 75th percentile.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2016, RY 2017, and RY 2018 found MBH to be partially compliant with three Subparts associated with Structure and Operations Standards.
  - MBH was partially compliant with 1 out of 7 categories within Subpart C: Enrollee Rights and Protections Regulations. The partially compliant category is Enrollee Rights.
  - MBH was partially compliant with 4 out of 10 categories and non-compliant with 1 out of 10 categories within Subpart D: Quality Assessment and Performance Improvement Regulations. The partially compliant categories are: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, 3) Practice Guidelines, and 4) Quality Assessment and Performance Improvement Program. The non-compliant category is Coordination and Continuity of Care.
  - MBH was partially compliant with 9 out of 10 categories within Subpart F: Federal and State Grievance System Standards Regulations. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers & Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions.
- MBH's overall PIP Project Performance Score was a Partial Met. They were a Partial Met on: Improvement Strategies (Interventions), Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement, and Sustainability of Documented Improvement.
  - Over the course of the PIP, MBH did not evidence significant improvement in the BHR and SAA indicators; the BHR-SA rates significantly worsened (increased).
- MBH's MY 2018 HEDIS 7- and 30-Day Follow-up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6+ years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- MBH's HEDIS 7-day Follow-up After Hospitalization for Mental Illness MY 2018 rate (QI 1) for the 18-64 and 65+ years age sets were significantly below the corresponding Statewide HealthChoices average. The QI2 rate for the 18-64 years age set was also significantly below the corresponding Statewide HealthChoices average.
- MBH's PA-specific 7-day Follow-up After Hospitalization for Mental Illness MY 2018 rates (QI 1) for the 18-64 and 65+ age years sets were significantly below the corresponding Statewide HealthChoices rates. The QI2 rate for the 18-64 age set was also significantly below the corresponding Statewide HealthChoices average.
- MBH's MY 2018 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- MBH's MY 2018 Initiation of AOD Treatment performance rates for all age cuts did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.

- MBH's MY 2018 Engagement rates for all age cuts were statistically significantly lower (worse) compared to the previous year.

Performance Measure Matrices

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

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

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

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

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

Table 6.2 quantifies the performance information presented in **Table 6.1**. It compares the BH-MCO's MY 2018 7- and 30-Day Follow-up After Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2014 through 2018. The last column compares the BH-MCO's MY 2018 rates to the corresponding MY 2018 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly: above (▲), below (▼), or no difference (═).

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

Quality Performance Measure	MY 2014 Rate	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2018 Rate	MY 2018 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	59.8%▼	55.8%▼	51.5% ▼	47.6%▼	50.4%▲	53.1% ▼
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	73.5%▼	69.9%▼	65.7% ▼	63.0%▼	66.2%▲	69.6% ▼
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	15.4% ═	15.2% ═	15.9%═	15.7%=	16.0%=	13.7% ▲

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

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

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

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

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

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

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

Quality Performance Measure	MY 2018		HEDIS MY 2018 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-up After Hospitalization for Mental Illness (All Ages)	37.3%	Not met	Above the 50th and below the 75th percentile
QI 2 – HEDIS 30-Day Follow-up After Hospitalization for Mental Illness (All Ages)	60.3%	Not met	Above the 50th and below the 75th percentile

[1] Rates shown are for ages 6 + years.

VII: Summary of Activities

Structure and Operations Standards

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

Performance Improvement Projects

- MBH submitted a Final PIP Report in 2019. MBH's overall PIP performance was a Partial Met.

Performance Measures

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

Quality Studies

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

Quality Studies

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

2018 Opportunities for Improvement MCO Response

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

2019 Strengths and Opportunities for Improvement

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

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Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B. OMHSAS-Specific PEPS Substandards

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

Table B.1: OMHSAS-Specific PEPS Substandards

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

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

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

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

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, a parenthetical notation "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020). In RY 2018, 16 OMHSAS-specific substandards were evaluated for MBH and its Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in RY 2018, along with the relevant categories.

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

Category (PEPS Standard)	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review [2]		
	Total	NR	RY 2018	RY 2017	RY 2016
Care Management					
Care Management (CM) Staffing (Standard 27)	1	0	0	0	1
Longitudinal Care Management (and Care Management Record Review) (Standard 28)	1	0	0	0	1
Complaints and Grievances					
Complaints (Standards 68 and 68.1)	4	0	0	0	4
Grievances and State Fair Hearings (Standards 71 and 71.1)	4	0	0	0	4
Denials					
Denials (Standard 72)	1	0	1	0	0
Executive Management					
County Executive Management (Standard 78)	1	0	0	0	1
BH-MCO Executive Management (Standard 86)	1	0	0	0	1
Enrollee Satisfaction					
Consumer/Family Satisfaction (Standard 108)	3	0	0	3	0
Total	16	0	1	3	12

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

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

OMHSAS: Office of Mental Health & Substance Abuse Services; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: Substandards not reviewed; RY: review year.

Format

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

Findings

Care Management

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

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

Category	PEPS Item	RY	Status by HC BH Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Standard 27.7	2016		All HC BH Contractors	
Longitudinal Care Management (and Care Management Record Review)	Standard 28.3	2016			All HC BH Contractors

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

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

MBH was partially compliant with Substandard 7 of Standard 27 (RY 2016):

Substandard 7: Other: Significant onsite review findings related to Standard 27.

PEPS Standard 28: Longitudinal Care Management (and Care Management Record Review). Results of the Care Management Record (CMR) review, denial review, and clinical interviews (summary) Sample of CMR Records.

MBH was non-compliant with Substandard 3 of Standard 28 (RY 2016):

Substandard 3: Other: Significant onsite review findings related to Standard 28.

Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances are MCO-specific review standards. Of the 7 substandards evaluated, MBH met 4 substandards and did not meet 3 substandards, as indicated in **Table C.3**.

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

Category	PEPS Item	RY	Status by HC BH Contractor			
			Met	Partially Met	Not Met	Not Reviewed
Complaints and Grievances						
Complaints	Substandard 68.1.1	2016	Lehigh	Bucks, Delaware	Montgomery, Northampton	
	Substandard 68.5	2016		All HC BH Contractors		
	Substandard 68.6 (RY 2016, RY 2017)	2016			All HC BH Contractors	
	Substandard	2016			All HC BH Contractors	

Category	PEPS Item	RY	Status by HC BH Contractor			
	68.7 (RY 2016, RY 2017)					
Grievances and State Fair Hearings	Substandard 71.1.1	2016		All HC BH Contractors		
	Substandard 71.5 (RY 2016, RY 2017)	2016		All HC BH Contractors		
	Substandard 71.5	2016			All HC BH Contractors	
	Substandard 71.6 (RY 2016, RY 2017)	2016			All HC BH Contractors	

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

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

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

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

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

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

Substandard 6 (RY 2016, RY 2017): The second-level complaint case file includes documentation that the member was contacted about the 2nd-level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.

Substandard 7 (RY 2016, RY 2017): Training rosters identify that all 2nd-level panel members have been trained. Include a copy of the training curriculum.

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

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

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

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, including but not limited to: The Member Handbook, Grievance decisions, written

notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

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

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

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

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

Denials

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2015. MBH was evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

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

Category	PEPS Item	RY	Status
Denials			
Denials	Standard 72.3	2018	Met

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

Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a County-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. MBH was partially compliant with two substandards. The status for these substandards is presented in **Table C.5**.

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

			Status By HC BH Contractor			
Category	PEPS Item	RY	Met	Partially Met	Not Met	Not Reviewed
Executive Management						
County Executive Management	Standard 78.5	2016	Lehigh, Northampton		Bucks	Delaware, Montgomery
BH-MCO Executive Management	Standard 86.3	2016			All HC BH Contractors	

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

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

Satisfaction; 8) Provider Satisfaction; 9) Network development, provider rate negotiation; and 10) Fraud, Waste, Abuse (FWA).

MBH was partially compliant with Substandard 5 of Standard 78 (RY 2016):

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

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

MBH was non-compliant with Substandard 3 of Standard 86 (RY 2016):

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

Enrollee Satisfaction

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the five MBH counties and were compliant on all three substandards. The status by county for these is presented in **Table C.6**.

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

Category	PEPS Item	RY	Status by HC BH Contractor	
			Met	Partially Met
Enrollee Satisfaction				
Consumer/Family Satisfaction	Standard 108.3	2017	All HC BH Contractors	
	Standard 108.4	2017	All HC BH Contractors	
	Standard 108.9	2017	All HC BH Contractors	

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