Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services
2021 External Quality Review Report
Magellan Behavioral Health

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Introduction

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs).[1] This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2021 EQRs for HealthChoices (HC) Behavioral Health MCOs (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.

Overview

HealthChoices (HC) Behavioral Health (BH) is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program. In such cases, the Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH Contractors, referred to in this report as "Primary Contractors." Primary Contractors, in turn, subcontract with a private-sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Forty-three (43) of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a BH-MCO. Twenty-four (24) counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties.

In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases the HealthChoices Oversight Entity is the Primary Contractor and, in other cases, multiple Primary Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. In the MBH managed care network, Bucks, Cambria, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors.

Objectives

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

- validation of performance improvement projects
- validation of MCO performance measures
- review to determine plan compliance with structure and operations standards established by the State (42 Code of Federal Regulations [CFR] 438.358), and
- validation of MCO network adequacy

Scope of EQR Activities

In accordance with the updates to the CMS EQRO Protocols released in late 2020,[2] this technical report includes seven core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Validation of Network Adequacy
V. Quality Studies
VI. 2020 Opportunities for Improvement – MCO Response
VII. 2021 Strengths and Opportunities for Improvement
VIII. Summary of Activities

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

conducted by IPRO, included a repeated measurement of two PMs: Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. The information for compliance with Medicaid Managed Care Regulations in **Section III** of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity, when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. **Section IV** discusses the validation of MCO network adequacy in relation to existing Federal and State standards that are covered in the Review of Compliance with Medicaid Managed Care Regulations, **Section III**. **Section V** discusses the Quality Study for the Certified Community Behavioral Health Clinic federal demonstration and the Integrated Community Wellness Centers program. **Section VI**, 2020 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2020 (MY 2019) EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. **Section VII** includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2021), 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 VIII** 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.

I: Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

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

CY 2021 saw the initial implementation stage of the new PIP project. During this stage, the PIP project was renamed "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders" (SUD) in accordance with feedback received by the BH-MCOs and Primary Contractors during the first year of the PIP. The MCOs submitted their recalculated baselines which allowed for any recalibration of their measures and subsequent interventions as needed.

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

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

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

Additionally, OMHSAS identified the following core performance indicators for the PEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[3] It contains two submeasures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure proposes to require 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure will measure discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended here to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" will include detox episodes only.
3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary MH

diagnosis, as defined by the PA-specific FUH measure, occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.

4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[4] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe Alcohol Use Disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

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

This PIP project will extend from January 2021 through December 2023, with initial PIP proposals submitted in 2020 and a final report due in September 2024. The report marks the 18th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

Technical Methods of Data Collection and Analysis

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

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

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

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[5] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 8 review elements listed below:

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

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

Findings

The MCO successfully submitted a PEDTAR PIP proposal in the fall of 2020 based on an initial baseline period of July 1, 2019, through June 30, 2020. Implementation began in early 2021. The MCO subsequently resubmitted a revised proposal based on the full CY 2020 data with goals, objectives, and interventions recalibrated as needed. IPRO reviewed all baseline PIP submissions for adherence to PIP design principles and standards, including alignment with the Statewide PIP aims and objectives as well as internal consistency and completeness. Clinical intervention highlights include comprehensive improvement to discharge planning addressing cultural factors, transportation barriers, and relapse prevention planning, incentivizing dually licensed outpatient providers, motivational interviewing training, and expanded knowledge, competency, and confidence among Certified Recovery Specialists and Certified Peer Specialists. For its population-based prevention strategy component, MBH is developing several educational information dissemination prevention activities to increase awareness around chronic pain, those prescribed opioid pain medication, and other SUD topics.

II: Validation of Performance Measures

Objectives

In MY 2020, OMHSAS's HealthChoices Quality Program required MCOs to run three performance measures as part of their quality assessment and performance improvement (QAPI) program: the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), a PA-specific Follow-Up After Hospitalization for Mental Illness, and a PA-specific Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2020. IPRO validated all three performance measures reported by each MCO for MY 2020 to ensure that the performance measures were implemented to specifications and state reporting requirements (42 C.F.R. § 438.330(b)(2).

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, Primary Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

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

Typically, HEDIS FUH undergoes annual updates to its specifications. Among the updates in 2020 (MY 2019), the National Committee for Quality Assurance (NCQA) added the following reporting strata for FUH, ages: 6–17, 18–64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are broken out by ages: 6–17, 18–64, and 6 and over (All Ages).

Measure Selection and Description

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

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

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

Eligible Population for HEDIS Follow-Up

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2020 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2020;
- 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, 2020, 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, 2020. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2020 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 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 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.

Eligible Population for PA-Specific Follow-Up

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2020 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a principal diagnosis of mental illness occurring between January 1 and December 2, 2020;
- 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 2, 2020, 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 2, 2020. The PA-specific measure has been adjusted to allow discharges up through December 2, 2020, which allows for the full 30-day follow-up period where same-day follow-up visits may be counted in the numerator.

PA-Specific Follow-Up Indicators

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

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

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

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

Quality Indicator Significance

Mental health disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2019, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year while an estimated 11.4 million adults in the nation had serious mental illness in the past year, which corresponds to 4.6% of all U.S. adults.[6] Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns, reduced use of preventive services, and substandard medical care that they receive.[7] Around one-third of adults with serious persistent mental illness (SPMI) in any given year did not receive any mental health services, showing a disparity among those with SPMI.[8] Further research suggests that more than half of those with SPMI did not receive services because they could not afford the cost of care.[9] Cost of care broke down as follows: 60.8% of patients' related expenses were attributed to loss of earnings, 31.5% were attributed to healthcare expenses, while 7.7% were attributed to payments for disability benefits.[10] 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.[11] As noted in *The State of Health Care Quality Report,*[12] 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.[13] 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.[14] 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.[15]

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.[16] Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow up with outpatient care.[17]

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

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS and results are reviewed for potential trends each year. MY 2020 results will be examined in the context of the COVID-19 pandemic, which has been implicated in rising prevalence of mental illness.[20] 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.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the PM for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and remeasurement of the PM for validation soon thereafter for MY 2007, and then for MY 2008. Remeasurements were

conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2020 study conducted in 2021 was the 12th remeasurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute facility. As with the Follow-Up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2020. This measure continued to be of interest to OMHSAS for the purposes of comparing Primary Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

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

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

Eligible Population

The entire eligible population was used for all 67 counties and 25 Primary Contractors participating in the MY 2020 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2020;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event; and
- The claim was clearly identified as a discharge.

The numerator comprised members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge. One significant change to this specification is the extension of the end date for discharges from December 1st to December 2nd to accommodate the full 30 days before the end of the measurement year.

Technical Methods of Data Collection and Analysis

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

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2020 (MY 2019), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a 3-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass® published percentiles for 7-day and 30-day FUH. This change in 2020 also coincided with a more prospective and proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2020 for both the 7-day and 30-day FUH All Ages rates based on their MY 2019 results. These MY 2019 results were reported in the 2020 BBA report.

HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each

underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH-MCO for an RCA and QIP. This process is further discussed in **Section VI**.

For REA, OMHSAS designated the PM 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.

Although not part of this report, OMHSAS sponsored in 2020 the rollout of an IPRO-hosted Tableau® server reporting platform, which allows users, including BH-MCOs and Primary Contractors, to interactively query data and produce reports on PMs. These reports include statistical or non-statistical summaries and comparisons of rates by various stratifications, including by demographics, such as race and ethnicity, as well as by participation status in the Medicaid Expansion program (Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2020). This interactive reporting provides an important tool for BH-MCOs and their HC Oversight Entities to set performance goals as well as monitor progress toward those goals.

Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HC Aggregate (Statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the Statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2019 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 2020) numerator,
*N*2 = Prior year (MY 2019) numerator,
*D*1 = Current year (MY 2020) denominator, and
*D*2 = Prior year (MY 2019) 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 2020) quality indicator rate, and
*p*2 = Prior year (MY 2019) quality indicator rate.

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

$$H_0: p1 = p2$$

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

Limitations

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

Conclusions and Comparative Findings

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

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

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

The HEDIS follow-up results for the All-Ages groups and 18-64 years old age group are compared to the HEDIS 2020 national percentiles to show BH-MCO and Primary Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile. The HEDIS follow-up results for the 6 to 17 years old age group are not compared to HEDIS benchmarks.

I: HEDIS Follow-Up Indicators

(a) Age Group: 18–64 Years Old

Table 2.1 shows the MY 2020 results for both the HEDIS 7-day and 30-day follow-up measures for members 18 to 64 years old compared to MY 2019.

Table 2.1: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
QI1 - HEDIS FUH 7-Day Follow-up (18-64 Years)									
Statewide	10454	28699	**36.4%**	35.9%	37.0%	35.9%	0.5	NO	Below 75th Percentile, Above 50th Percentile
Magellan	1740	4961	**35.1%**	33.7%	36.4%	35.7%	-0.7	NO	Below 75th Percentile, Above 50th Percentile
Bucks	310	815	**38.0%**	34.6%	41.4%	38.3%	-0.3	NO	Below 75th Percentile, Above 50th Percentile
Cambria	125	379	**33.0%**	28.1%	37.8%	29.3%	3.7	NO	Below 50th Percentile, Above 25th Percentile
Delaware	317	993	**31.9%**	29.0%	34.9%	33.5%	-1.5	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	372	1037	**35.9%**	32.9%	38.8%	36.5%	-0.6	NO	Below 75th Percentile, Above 50th Percentile

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
Montgomery	405	1106	**36.6%**	33.7%	39.5%	38.1%	-1.5	NO	Below 75th Percentile, Above 50th Percentile
Northampton	211	631	**33.4%**	29.7%	37.2%	34.3%	-0.9	NO	Below 50th Percentile, Above 25th Percentile
QI2 - HEDIS FUH 30-Day Follow-up (18-64 Years)									
Statewide	15978	28699	**55.7%**	55.1%	56.3%	55.8%	-0.1	NO	Below 75th Percentile, Above 50th Percentile
Magellan	2771	4961	**55.9%**	54.5%	57.2%	58.1%	-2.2	YES	Below 75th Percentile, Above 50th Percentile
Bucks	490	815	**60.1%**	56.7%	63.5%	56.6%	3.5	NO	Below 75th Percentile, Above 50th Percentile
Cambria	242	379	**63.9%**	58.9%	68.8%	64.8%	-0.9	NO	At or Above 75th Percentile
Delaware	481	993	**48.4%**	45.3%	51.6%	51.4%	-2.9	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	576	1037	**55.5%**	52.5%	58.6%	60.1%	-4.5	YES	Below 75th Percentile, Above 50th Percentile
Montgomery	636	1106	**57.5%**	54.5%	60.5%	58.8%	-1.3	NO	Below 75th Percentile, Above 50th Percentile
Northampton	346	631	**54.8%**	50.9%	58.8%	60.5%	-5.7	YES	Below 75th Percentile, Above 50th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.1 is a graphical representation of MY 2020 HEDIS FUH 7- and 30-Day follow-up rates in the 18 to 64 years old population for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

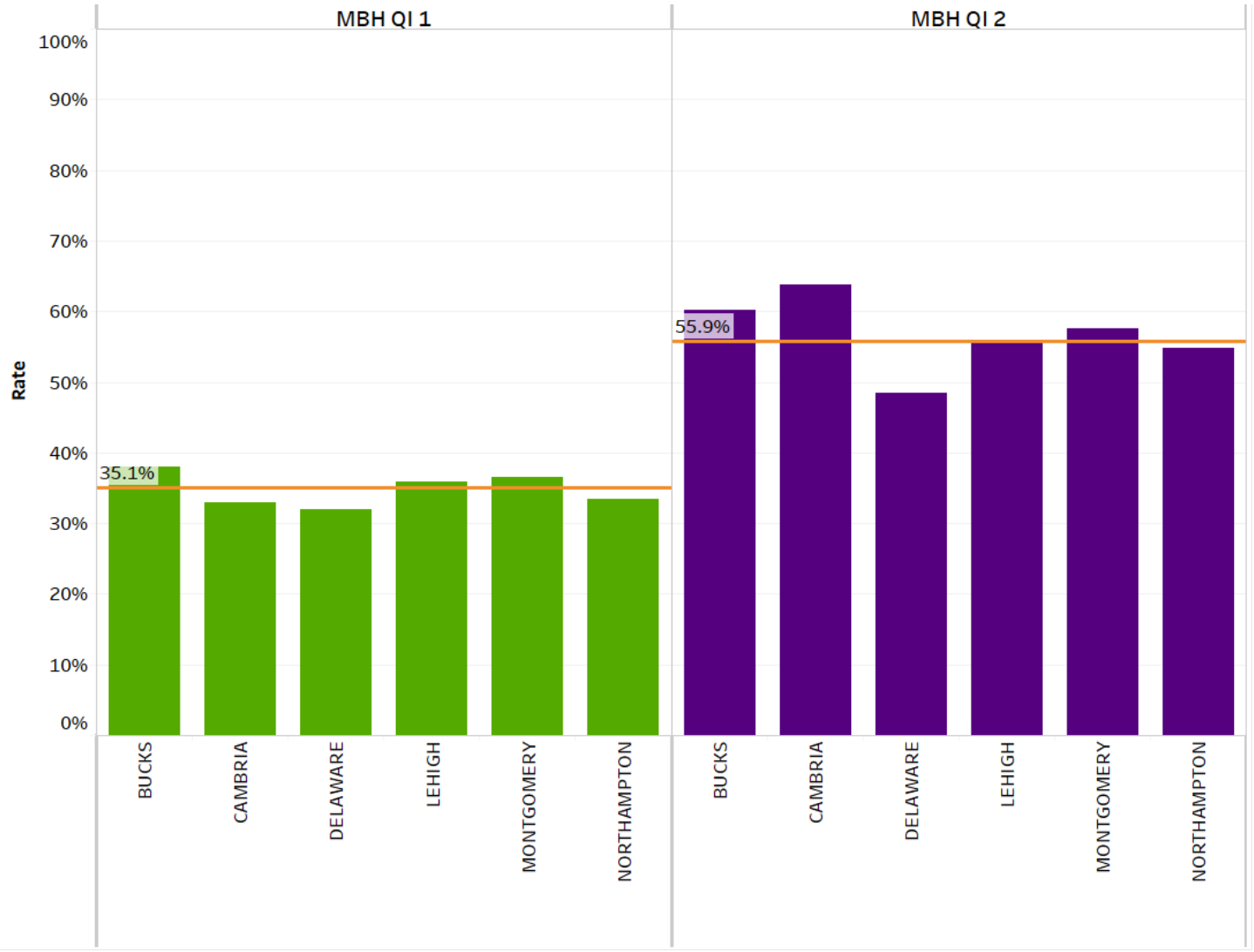

Figure 2.1: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

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

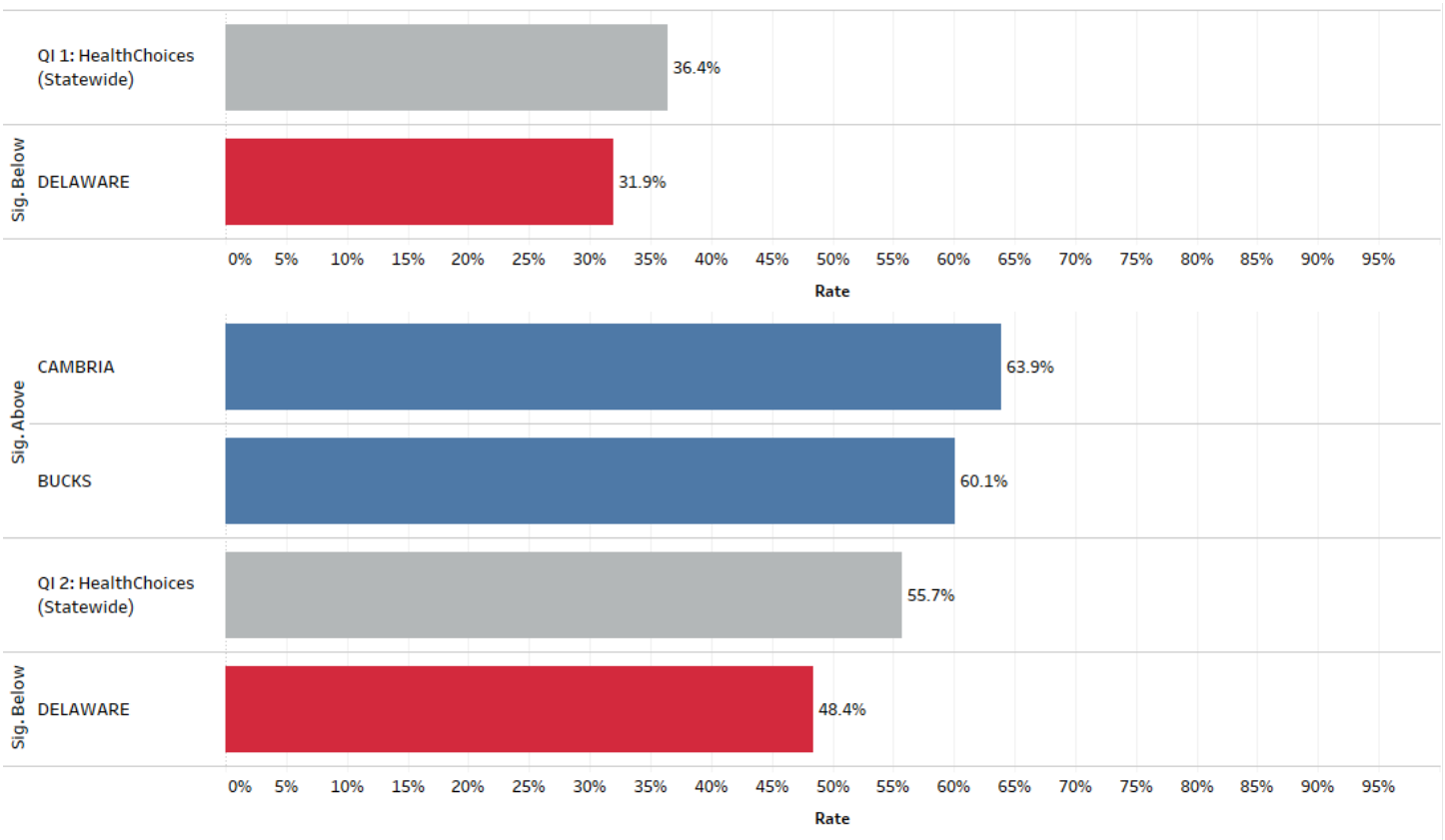

Figure 2.2: Statistically Significant Differences in MBH Contractor MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years). MBH contractor MY 2020 HEDIS FUH rates for 18–64 years of age that are significantly different than HC BH (statewide) MY 2020 HEDIS FUH rates (18–64 years).

(b) Overall Population: 6+ Years Old

The MY 2020 HC Aggregate HEDIS and MBH are shown in **Table 2.2**.

Table 2.2: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
QI1 - HEDIS FUH 7-Day Follow-up (Overall)									
Statewide	14501	36459	**39.8%**	39.3%	40.3%	39.8%	-0.0	NO	Below 75th Percentile, Above 50th Percentile
Magellan	2282	6240	**36.6%**	35.4%	37.8%	38.4%	-1.8	YES	Below 50th Percentile, Above 25th Percentile
Bucks	409	1031	**39.7%**	36.6%	42.7%	40.5%	-0.9	NO	Below 75th Percentile, Above 50th Percentile
Cambria	161	491	**32.8%**	28.5%	37.0%	31.7%	1.1	NO	Below 50th Percentile, Above 25th Percentile
Delaware	409	1227	**33.3%**	30.7%	36.0%	36.9%	-3.6	NO	Below 50th Percentile, Above 25th Percentile
Lehigh	476	1277	**37.3%**	34.6%	40.0%	37.7%	-0.4	NO	Below 50th Percentile, Above 25th Percentile

	MY 2020						MY 2020 Rate Comparison		
				95% CI			to MY 2019		
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD	to MY 2020 HEDIS Medicaid Percentiles
Montgomery	545	1410	**38.7%**	36.1%	41.2%	41.6%	-2.9	NO	Below 50th Percentile, Above 25th Percentile
Northampton	282	804	**35.1%**	31.7%	38.4%	37.6%	-2.5	NO	Below 50th Percentile, Above 25th Percentile
QI2 - HEDIS FUH 30-Day Follow-up (Overall)									
Statewide	21673	36459	**59.4%**	58.9%	60.0%	60.3%	-0.9	YES	Below 50th Percentile, Above 25th Percentile
Magellan	3639	6240	**58.3%**	57.1%	59.5%	61.4%	-3.1	YES	Below 50th Percentile, Above 25th Percentile
Bucks	642	1031	**62.3%**	59.3%	65.3%	60.7%	1.6	NO	Below 75th Percentile, Above 50th Percentile
Cambria	325	491	**66.2%**	61.9%	70.5%	66.4%	-0.2	NO	Below 75th Percentile, Above 50th Percentile
Delaware	627	1227	**51.1%**	48.3%	53.9%	55.6%	-4.5	YES	Below 25th Percentile
Lehigh	742	1277	**58.1%**	55.4%	60.9%	62.4%	-4.3	YES	Below 50th Percentile, Above 25th Percentile
Montgomery	846	1410	**60.0%**	57.4%	62.6%	62.4%	-2.4	NO	Below 50th Percentile, Above 25th Percentile
Northampton	457	804	**56.8%**	53.4%	60.3%	64.1%	-7.2	YES	Below 50th Percentile, Above 25th Percentile

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.3 is a graphical representation of the MY 2020 HEDIS follow-up rates for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

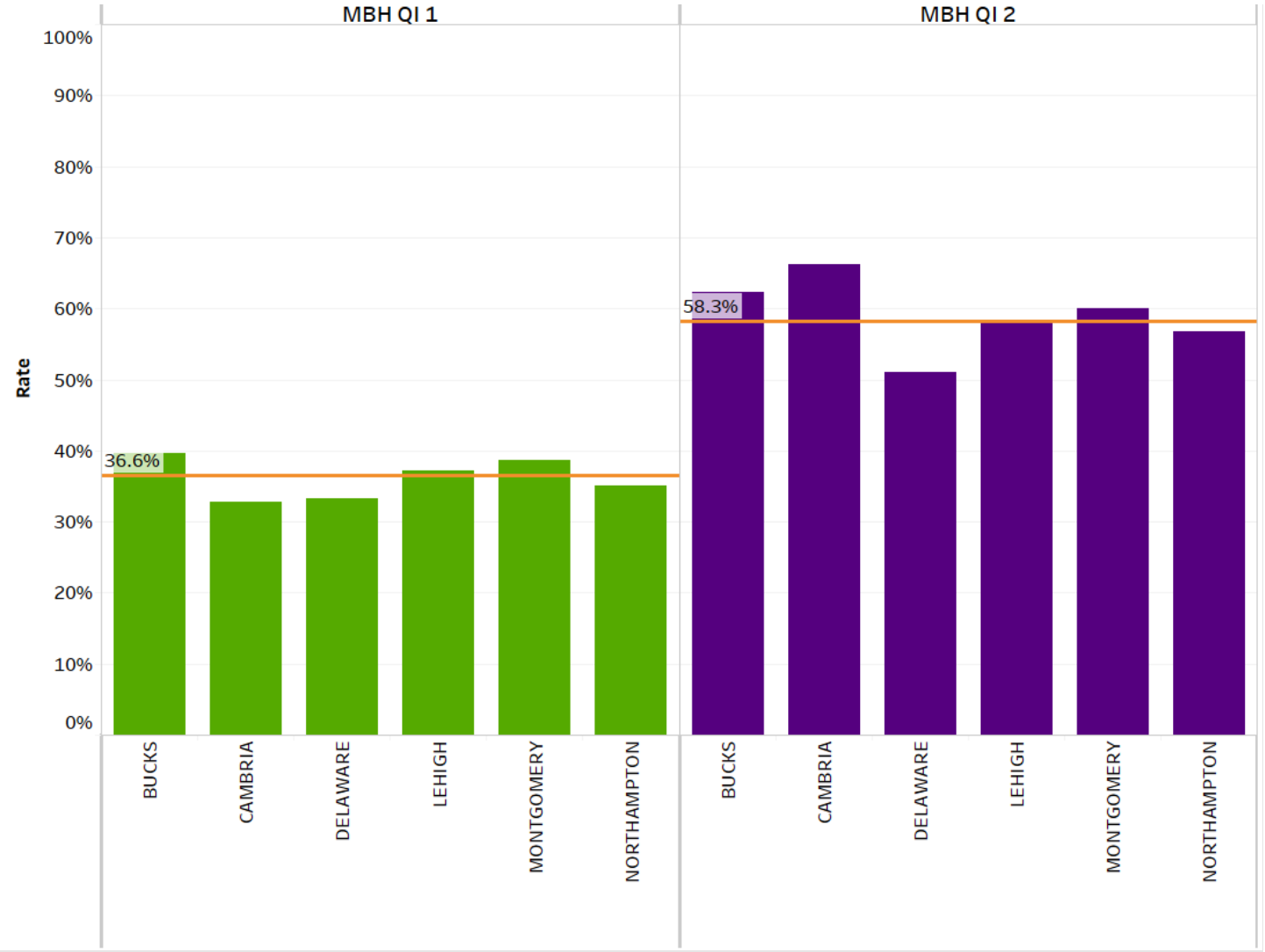

Figure 2.3: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

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

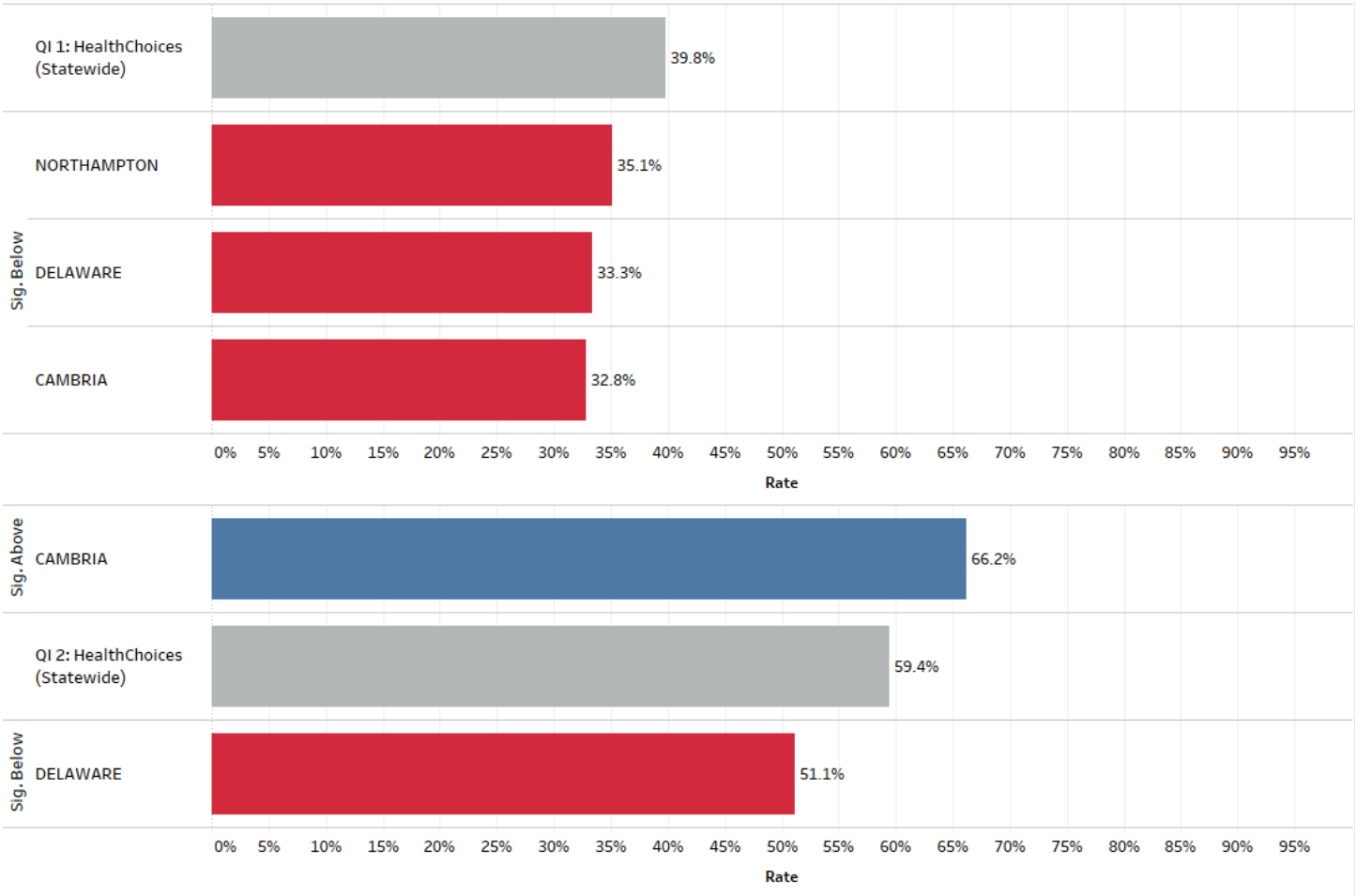

Figure 2.4: Statistically Significant Differences in MBH Contractor MY 2020 HEDIS FUH 7- and 30-Day Follow-up Rates (All Ages). MBH contractor MY 2020 HEDIS FUH rates for all ages that are significantly different than HC BH (statewide) MY 2020 HEDIS FUH rates (all ages).

(c) Age Group: 6–17 Years Old

Table 2.3 shows the MY 2020 results for both the HEDIS 7-day and 30-day follow-up measures for members aged 6–17 years compared to MY 2019.

Table 2.3: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6–17 Years)

	MY 2020						MY 2020 Rate Comparison to MY 2019	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD
QI1 - HEDIS FUH 7-Day Follow-up (6-17 Years)								
Statewide	3860	6993	**55.2%**	54.0%	56.4%	55.4%	-0.2	NO
Magellan	509	1170	**43.5%**	40.6%	46.4%	49.4%	-5.9	YES
Bucks	93	199	**46.7%**	39.6%	53.9%	48.2%	-1.5	NO
Cambria	34	103	**33.0%**	23.4%	42.6%	43.8%	-10.7	NO
Delaware	87	211	**41.2%**	34.4%	48.1%	51.3%	-10.1	YES
Lehigh	94	215	**43.7%**	36.9%	50.6%	43.4%	0.3	NO

Measure	MY 2020 (N)	MY 2020 (D)	MY 2020 %	95% CI Lower	95% CI Upper	MY 2019 %	MY 2020 Rate Comparison to MY 2019 PPD[1]	MY 2020 Rate Comparison to MY 2019 SSD
Montgomery	133	283	**47.0%**	41.0%	53.0%	55.6%	-8.6	YES
Northampton	68	159	**42.8%**	34.8%	50.8%	49.5%	-6.8	NO
QI2 - HEDIS FUH 30-Day Follow-up (6-17 Years)								
Statewide	5393	6993	**77.1%**	76.1%	78.1%	78.8%	-1.7	YES
Magellan	820	1170	**70.1%**	67.4%	72.8%	74.8%	-4.7	YES
Bucks	144	199	**72.4%**	65.9%	78.8%	73.6%	-1.2	NO
Cambria	79	103	**76.7%**	68.0%	85.3%	76.8%	-0.1	NO
Delaware	140	211	**66.4%**	59.7%	73.0%	73.0%	-6.7	NO
Lehigh	151	215	**70.2%**	63.9%	76.6%	73.2%	-2.9	NO
Montgomery	200	283	**70.7%**	65.2%	76.2%	76.1%	-5.4	NO
Northampton	106	159	**66.7%**	59.0%	74.3%	77.4%	-10.7	YES

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.5 is a graphical representation of the MY 2020 HEDIS FUH 7- and 30-Day follow-up rates in the 6 to 17 years old population for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

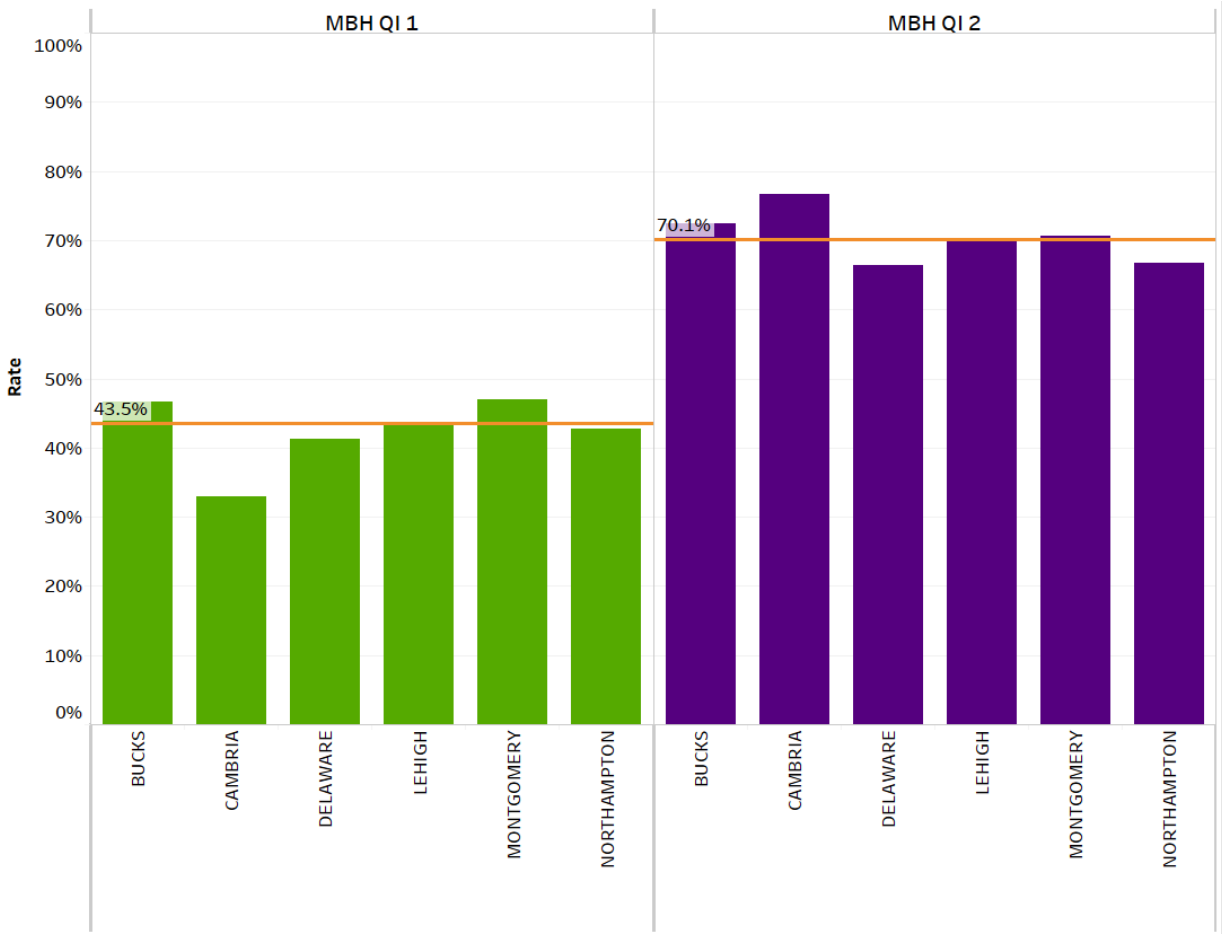

Figure 2.5: MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

Figure 2.6 shows the HC BH (Statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rates.

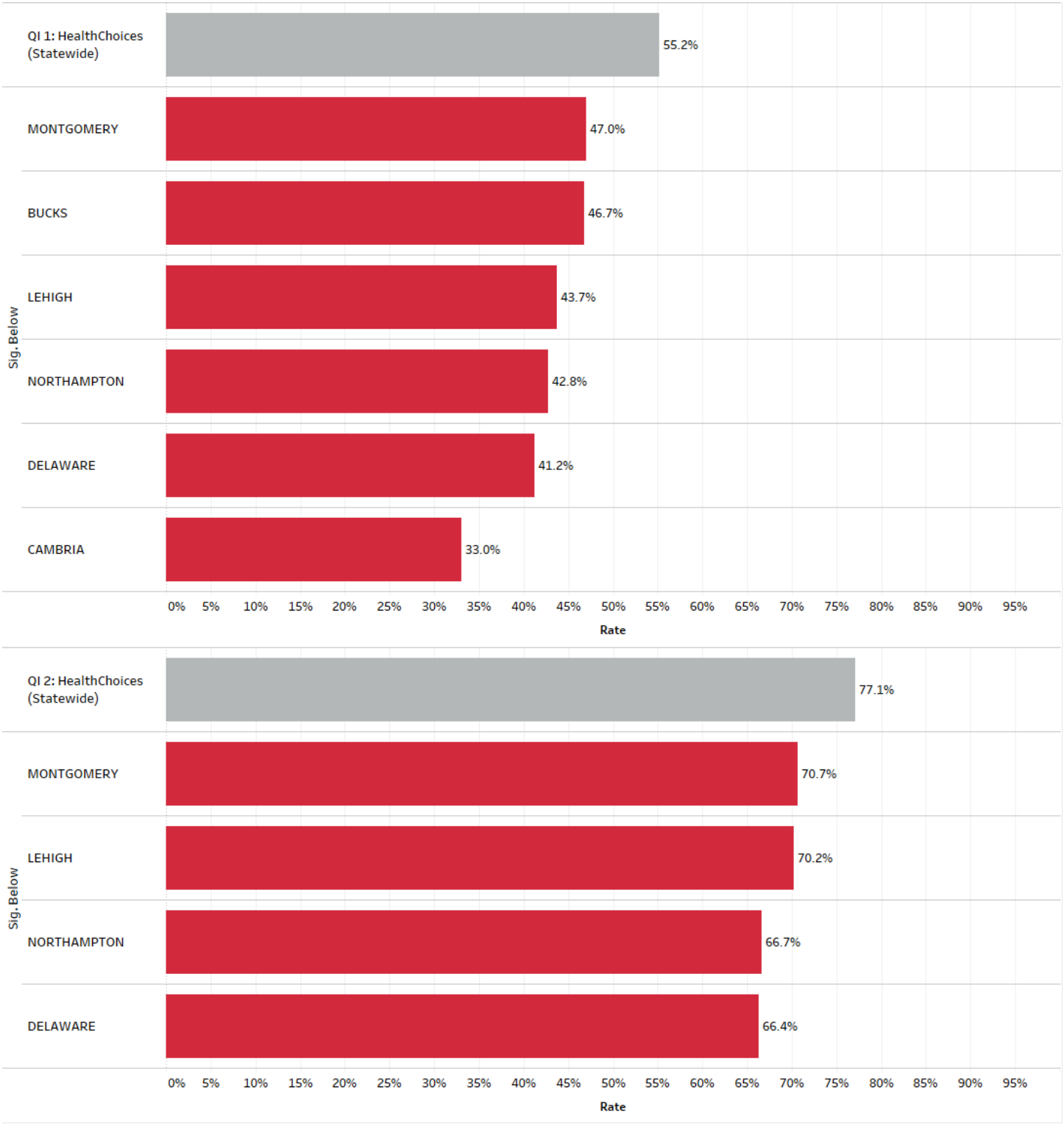

Figure 2.6: Statistically Significant Differences in MBH Contractor MY 2020 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years). MBH contractor MY 2020 HEDIS FUH rates for 6–17 years of age that are significantly different than HC BH (statewide) MY 2020 HEDIS FUH rates (6–17 years).

II: PA-Specific Follow-Up Indicators

(a) Overall Population: 6+ Years Old

Table 2.4 shows the MY 2020 PA-specific FUH 7- and 30-day follow-up indicators for all ages compared to MY 2019.

Table 2.4: MY 2020 PA-Specific FUH 7- and 30-Day Follow-up Indicators (All Ages)

	MY 2020						MY 2020 Rate Comparison to MY 2019	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[1]	SSD
QI A - PA-Specific FUH 7-Day Follow-up (Overall)								
Statewide	19124	36580	**52.3%**	51.8%	52.8%	52.9%	-0.6	NO
Magellan	3059	6240	**49.0%**	47.8%	50.3%	51.4%	-2.4	YES
Bucks	532	1031	**51.6%**	48.5%	54.7%	51.3%	0.3	NO
Cambria	254	491	**51.7%**	47.2%	56.3%	50.1%	1.6	NO
Delaware	535	1227	**43.6%**	40.8%	46.4%	47.0%	-3.4	NO
Lehigh	604	1277	**47.3%**	44.5%	50.1%	51.1%	-3.8	YES
Montgomery	752	1410	**53.3%**	50.7%	56.0%	54.7%	-1.4	NO
Northampton	382	804	**47.5%**	44.0%	51.0%	53.4%	-5.8	YES
QI B - PA-Specific FUH 30-Day Follow-up (Overall)								
Statewide	24982	36580	**68.3%**	67.8%	68.8%	69.5%	-1.2	YES
Magellan	4007	6240	**64.2%**	63.0%	65.4%	67.7%	-3.5	YES
Bucks	688	1031	**66.7%**	63.8%	69.7%	65.7%	1.0	NO
Cambria	355	491	**72.3%**	68.2%	76.4%	71.7%	0.6	NO
Delaware	685	1227	**55.8%**	53.0%	58.6%	62.1%	-6.2	YES
Lehigh	822	1277	**64.4%**	61.7%	67.0%	69.3%	-4.9	YES
Montgomery	950	1410	**67.4%**	64.9%	69.9%	68.6%	-1.2	NO
Northampton	507	804	**63.1%**	59.7%	66.5%	71.2%	-8.2	YES

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.

MY: measurement year; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.7 is a graphical representation of the MY 2020 PA-specific follow-up rates for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

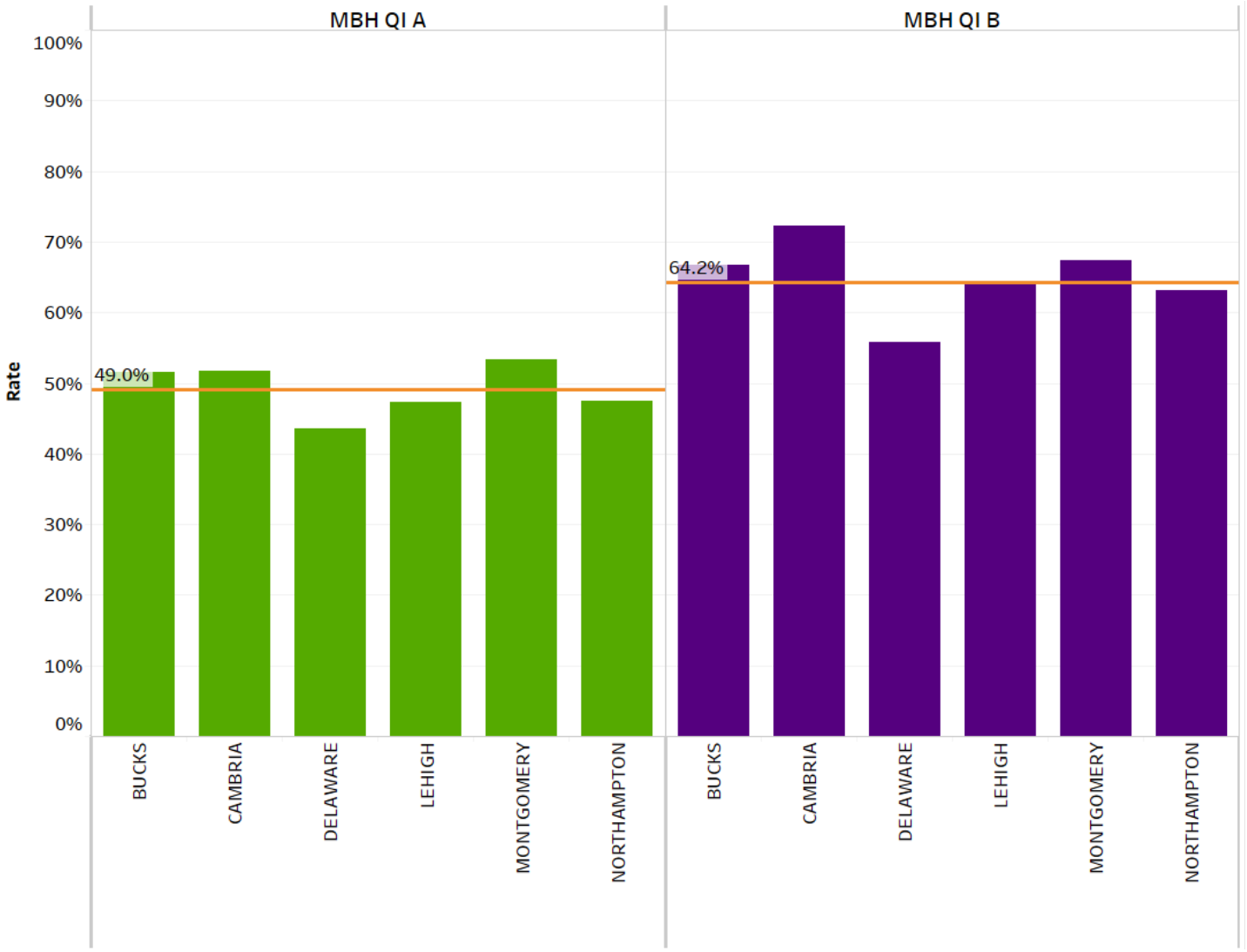

Figure 2.7: MY 2020 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

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

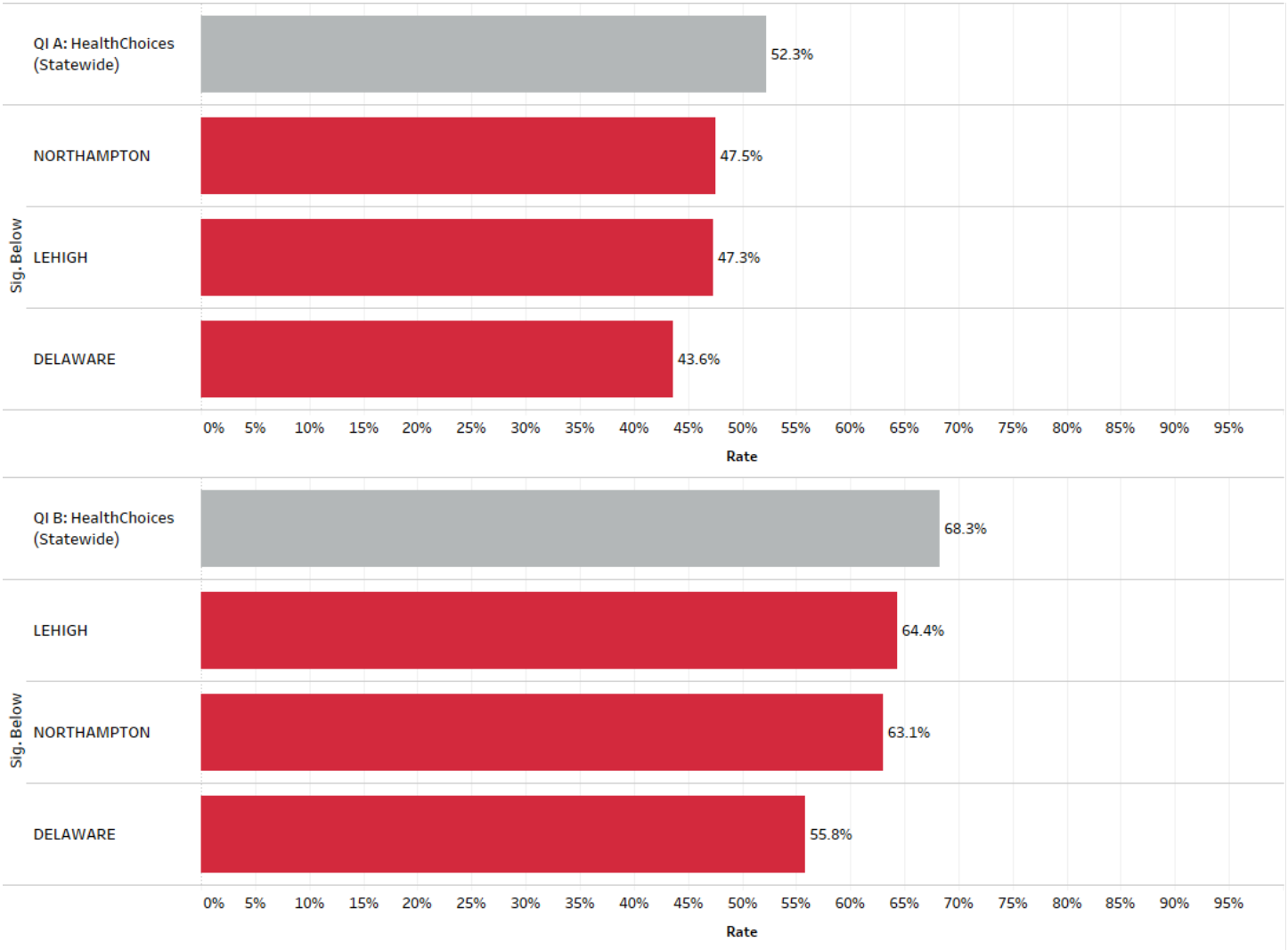

Figure 2.8: Statistically Significant Differences in MBH Contractor MY 2020 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages). MBH contractor MY 2020 PA-specific FUH rates for all ages that are significantly different than HC BH (statewide) MY 2020 PA-specific FUH rates (all ages).

III. Readmission Indicators

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2020 to MY 2019 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the *Z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the Percentage Point Difference (PPD) between the rates.

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

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

Table 2.5: MY 2020 REA Readmission Indicators

	MY 2020						MY 2020 Rate Comparison to MY 2019	
				95% CI				
Measure[1]	(N)	(D)	%	Lower	Upper	MY 2019 %	PPD[2]	SSD
Inpatient Readmission								
Statewide	6134	45174	**13.6%**	13.3%	13.9%	13.5%	0.1	NO
Magellan	1289	8266	**15.6%**	14.8%	16.4%	15.3%	0.3	NO
Bucks	191	1374	**13.9%**	12.0%	15.8%	16.6%	-2.7	YES
Cambria	98	640	**15.3%**	12.4%	18.2%	14.7%	0.6	NO
Delaware	259	1650	**15.7%**	13.9%	17.5%	14.3%	1.4	NO
Lehigh	297	1701	**17.5%**	15.6%	19.3%	15.3%	2.2	NO
Montgomery	287	1858	**15.4%**	13.8%	17.1%	15.7%	-0.2	NO
Northampton	157	1043	**15.1%**	12.8%	17.3%	15.1%	-0.1	NO

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

[2] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2020 and MY 2019 rates.

MY: measurement year; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.9 is a graphical representation of the MY 2020 readmission rates for MBH and its associated Primary Contractor. The orange line represents the MCO average.

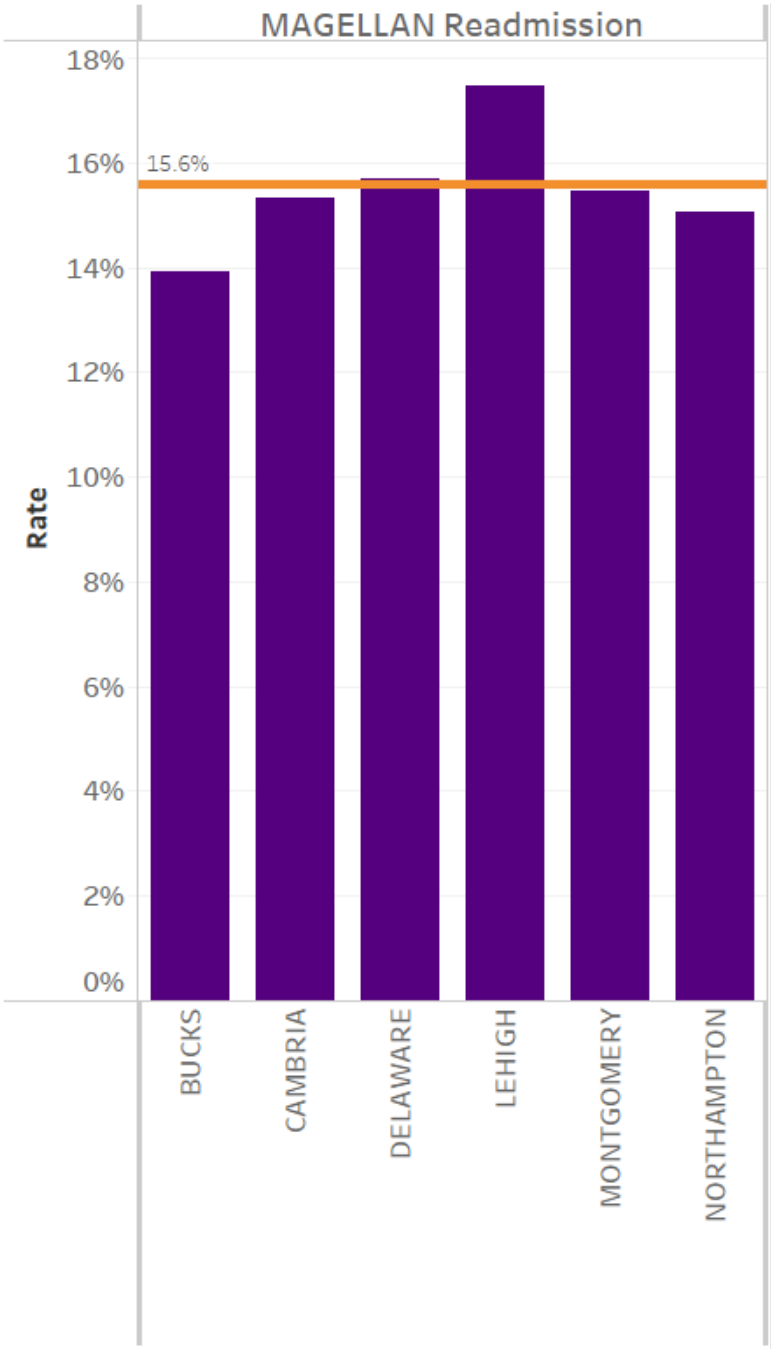

Figure 2.9: MY 2020 REA Readmission Rates for MBH Primary Contractors.

Figure 2.10 shows the Health Choices BH (Statewide) readmission rate and the individual MBH Primary Contractors that performed statistically significantly higher (red) or lower (blue) than the HC BH Statewide rate.

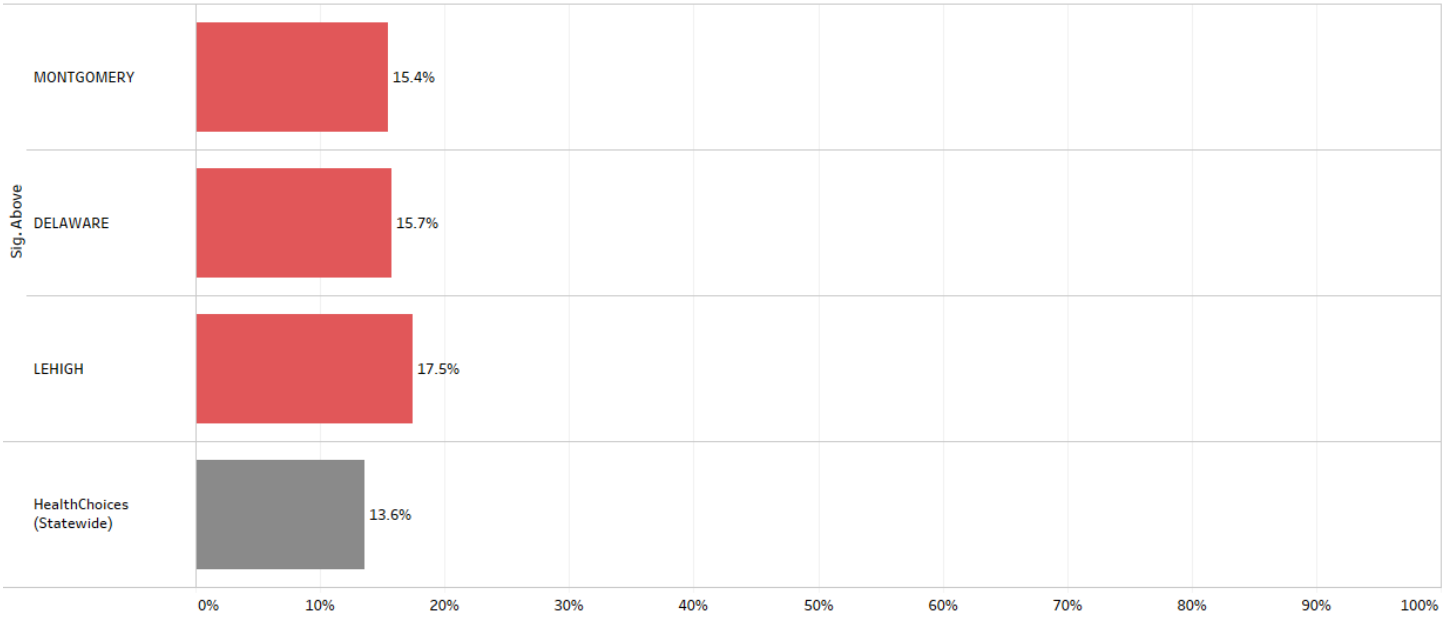

Figure 2.10: Statistically Significant Differences in MBH MY 2020 Readmission Rates (All Ages). MBH MY 2020 Readmission rates for all ages that are significantly different than HC BH (statewide) MY 2020 Readmission rates (all ages).

Recommendations

- As with most reporting years, it is important to note that there were some changes to the HEDIS MY 2020 specifications, including removal of the mental health provider requirement for specific types of follow-up visits, and the addition to the numerator of certain place of service types, including visits in behavioral healthcare settings and telehealth. MY 2020 also coincided with the COVID-19 pandemic, which likely negatively impacted the ability of payers and providers to ensure timely follow-up services after hospitalization. Understanding the precise nature and extent of that impact, however, will require more research. That said, efforts should continue to be made to improve Follow-Up After Hospitalization for Mental Illness performance, particularly for those BH-MCOs that performed below the HC BH Statewide rate. The following are recommendations that are informed by the MY 2020 review:
  - The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2020. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health care follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments in 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 were varied with two Primary Contractors performing at or above the HEDIS Quality Compass 75th percentile for the 7-Day follow-up and five Primary Contractors performing at or above the HEDIS Quality Compass 75th percentile for the 30-Day follow-up. Although the BH-MCO improved its rate for the 7-Day, the rate for 30-Day remained the same. As previously noted, although not enumerated in this report, further stratified comparisons such as Medicaid Expansion versus non-Medicaid Expansion, were carried out in a separate 2021 (MY 2020) FUH "Rates Report" produced by the EQRO and made available to BH-MCOs in an interactive Tableau workbook. BH-MCOs and Primary Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For example, it is important for BH-

MCOs and Primary Contractors to analyze performance rates by racial and ethnic categories and to target the populations where racial and ethnic disparities may exist. It is recommended that BH-MCOs and Primary Contractors 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 2021 (MY 2020) FUH Rates Report is one source BH-MCOs can use to investigate potential health disparities in FUH.

- BH-MCOs and Primary Contractors are encouraged to review the 2021 (MY 2020) FUH Rates Report in conjunction with the corresponding 2021 (MY 2020) inpatient psychiatric readmission Rates (REA) Report. Focused review of those individuals that had an inpatient psychiatric readmission in less than 30 days is recommended to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.
- One of MBH's Primary Contractors, Cambria, turned in follow-up rates that met or exceeded the HEDIS 2021 75th percentile. Other Primary Contractors in MBH's network could benefit from drawing lessons or at least general insights from its success.

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

MY 2020 saw a slight increase (worsening) for the MCO in readmission rates after psychiatric discharge. MBH's readmission rates after psychiatric discharge for the Medicaid Managed Care (MMC) population remains above 10% (and statistically significantly above the HC BH Statewide average). As a result, many recommendations previously made remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the past PIP cycle, the recommendations may assist in future discussions.

In response to the 2020 study, the following general recommendations are applicable to all five participating BH-MCOs:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2020 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 2019, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A new PIP starting in 2020 builds on the previous PIP by, among other things, including a performance indicator that measures MH-related readmissions within 30 days of a discharge for SUD. BH-MCOs are expected to bring about meaningful improvement in BH readmission rates for this subpopulation with comorbid BH conditions and for their HC BH members more generally. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.
  - The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate 2021 (MY 2020) REA "Rates Report" produced by the EQRO which is being made available to BH MCOs in an interactive Tableau workbook.
  - BH-MCOs and Primary Contractors are encouraged to review the 2021 (MY 2020) REA Rates Report in conjunction with the aforementioned 2021 (MY 2020) FUH Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission within 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.
  - Bucks County was notable in its statistically significant decrease in readmissions. Other Primary Contractors in MBH's network may be able to draw insights from its success in MY 2020.

III: Compliance with Medicaid Managed Care Regulations

Objectives

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the MMC structure and operations standards. In review year (RY) 2020, 67 Pennsylvania counties participated in this compliance evaluation.

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

Bucks, Cambria, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors. In Calendar Year 2018 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 3-year period. **Table 3.1** shows the name of the HC Oversight Entity, the associated HC Primary Contractor(s), and the county(ies) encompassed by each Primary Contractor.

Table 3.1: MBH HealthChoices Oversight Entities, Primary Contractors and Counties

HealthChoices Oversight Entity	Primary 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

MBH: Magellan Behavioral Health.

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

Description of Data Obtained

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2020 and entered into the PEPS Application as of March 2021 for RY 2020. 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 HC Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to collect or capture additional reviewer comments. Based on the PEPS Application, an HC 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 previously 2nd-level grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

In accordance with the updates to the CMS EQRO Protocols released in late 2020,[21] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included updates to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in 42 C.F.R. 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. In addition, findings for RY 2020 are presented here under the new rubric of the three "CMS sections": Standards, including Enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up were correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating 3-year schedule for all five BH-MCOs. This may, in turn, change the category tally of standards from one reporting year to the next. In 2020 (RY 2019), 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.

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 2020 crosswalks of PEPS substandards to pertinent BBA regulations and to pertinent OMHSAS-specific PEPS substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the HC Oversight Entities and their subcontracted BH-MCOs occurs over a 3-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The 3-year period is alternatively referred to as the Active Review period. The PEPS substandards from RY 2020, RY 2019, and RY 2018 provided the information necessary for the 2020 assessment. Those triennial standards not reviewed through the PEPS system in RY 2020 were evaluated on their performance based on RY 2019 and/or RY 2018 determinations, or other supporting documentation, if necessary. For those HC Oversight Entities that completed their Readiness Reviews within the 3-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 72 unique substandards were applicable for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2020, 2019, and 2018). In addition, 18 OMHSAS-specific Substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Substandards that are not required as part of BBA regulations but are reviewed within the 3-year cycle to evaluate the BH-MCO and the associated HC Oversight Entity against other state-specific Structure and Operations Standards.

Table 3.2 tallies the PEPs Substandard reviews used to evaluate the HC Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2018–2020). Substandard counts under RY 2020 comprised annual and triennial substandards. Substandard counts under RYs 2019 and 2018 comprised only triennial substandards. By definition, only the last review of annual substandards is counted in the 3-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 94, differs from the unique count of substandards that came under active review (72).

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

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
BBA Regulation	Total	NR	2020	2019	2018
CMS EQR Protocol 3 "sections": Standards, including enrollee rights and protections					
Assurances of adequate capacity and services (42 C.F.R. § 438.207)	5	-	5	-	-
Availability of Services (42 C.F.R § 438.206, 42 C.F.R. § 10(h))	24	-	18	2	4
Confidentiality (42 C.F.R. § 438.224)	1	-	-	-	1
Coordination and continuity of care (42 C.F.R. § 438.208)	2	-	-	2	-
Coverage and authorization of services (42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114)	4	-	2	2	-
Health information systems (42 C.F.R. § 438.242)	1	-	-	-	1
Practice guidelines (42 C.F.R. § 438.236)	6	-	-	2	4
Provider selection (42 C.F.R. § 438.214)	3	-	3	-	-
Subcontractual relationships and delegation (42 C.F.R. § 438.230)	8	-	-	-	8
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program (42 C.F.R. § 438.330)	26	-	19	-	7
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems (42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424)	14	-	2	12	-
Total	**94**	-	**49**	**20**	**25**

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

[2] The number of substandards that came under active review during the cycle specific to the review year. Because substandards may cross-walk to more than one category, the total tally of sub-standard reviews (94) differs from the unique count of sub-standards that came under active review (72).

RY: review year; BBA: Balanced Budget Act; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: substandards not reviewed; NR: substandards not reviewed; CMS: Centers for Medicare and Medicaid Services; EQR: external quality review; C.F.R: Code of Federal Regulations.

Determination of Compliance

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

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

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[22] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) program, and Grievance System.

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

Findings

Seventy-two (72) unique PEPS substandards were used to evaluate MBH and its Oversight Entities compliance with BBA regulations in RY 2020.

Standards, including Enrollee Rights and Protections

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

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

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Assurances of adequate capacity and services 42 C.F.R. § 438.207	5	Compliant	All MBH Primary Contractors	1.1, 1.2, 1.4, 1.5, 1.6	-	-
Availability of Services 42 C.F.R § 438.206, 42 C.F.R. § 10(h)	24	Compliant	All MBH Primary Contractors	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 28.2, 93.1, 93.2, 93.3, 93.4	-	-
Confidentiality 42 C.F.R. § 438.224	1	Compliant	All MBH Primary Contractors	120.1	-	-
Coordination and continuity of care 42 C.F.R. § 438.208	2	Compliant	All MBH Primary Contractors	28.1, 28.2	-	-
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42	4	Partial	All MBH Primary Contractors	28.1, 28.2, 72.2	72.1	-

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
C.F.R. § 441, Subpart B, and § 438.114						
Health information systems 42 C.F.R. § 438.242	1	Compliant	All MBH Primary Contractors	120.1	-	-
Practice guidelines 42 C.F.R. § 438.236	6	Compliant	All MBH Primary Contractors	28.1, 28.2, 93.1, 93.2, 93.3, 93.4	-	-
Provider selection 42 C.F.R. § 438.214	3	Compliant	All MBH Primary Contractors	10.1, 10.2, 10.3	-	-
Subcontractual relationships and delegation 42 C.F.R. § 438.230	8	Compliant	All MBH Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-

MCO: managed care organization; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

There are nine (9) categories within Standards, including Enrollee Rights and Protections. MBH was compliant with 8 categories and partially compliant with 1 category.

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, including Enrollee Rights and Protections. MBH and its Primary Contractors were reviewed on all 54 substandards. MBH and its Primary Contractors were compliant in 53 instances and partially compliant in one instance. 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.

Coverage and Authorization of Services

MBH was partially compliant with Coverage and Authorization of Services due to partial compliance with Substandard 1 within PEPS Standard 72 (RY 2020).

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

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

Quality Assessment and Performance Improvement (QAPI) Program

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid Managed Care program, the HealthChoices Program, are available and accessible to MCO enrollees. The PEPS documents for each Primary Contractor include an assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: Compliance with Quality Assessment and Performance Improvement Program

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Quality assessment and performance improvement program 42 C.F.R. § 438.330	26	Partial	All MBH Primary Contractors	91.1, 91.2, 91.3, 91.4, 91.5, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 104.1, 104.3, 104.4	-	104.2

MCO: managed care organization; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with 25 substandards and non-compliant with 1 substandard.

Quality Assessment and Performance Improvement MCO Status

MBH was partially compliant with Quality Assessment and Performance Improvement Program due to non-compliance compliance with Substandard 2 within Standard 104 (RY 2020).

Standard 104: There is a provision for regular reporting to the Department of Human Services (DHS) on accurate and timely QM data.

Substandard 2: The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.

Grievance System

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

Table 3.5: Compliance with Grievance System

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Grievance and appeal systems 42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	14	Partial	All MBH Primary Contractors	68.1, 68.2, 68.7, 71.2, 71.4, 71.7, 72.2	68.3, 68.4, 68.9, 71.1, 71.3, 71.9, 72.1	-

MCO: managed care organization; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with 7 substandards and partially compliant with 7 substandards.

Grievance and Appeal Systems

MBH was partially compliant with Grievance and Appeal Systems due to partial compliance with 3 substandards of PEPS Standard 68 (RY 2019), 4 substandards of PEPS Standard 71 (RY 2019), and 1 substandard of PEPS Standard 72 (RY 2020).

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.

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 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.

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.

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 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.

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

Substandard 1: See substandard description and determination of compliance under Coverage and Authorization of Services.

IV: Validation of Network Adequacy

Objectives

As set forth in 42 CFR §438.358, validation of network adequacy is a mandatory EQR activity. The purpose of this section is to assess the BH-MCO's network adequacy in accordance with standards established under 42 CFR § 438.68(b) (1)(iii) and 457.1218.

Description of Data Obtained

For the 2020 review year, the BH-MCO's network adequacy was assessed based on compliance with certain federal and OMHSAS-specific standards that were crosswalked to standards falling directly or indirectly under 42 CFR § 438.68(b) (1)(iii) and 457.1218. Compliance status was determined as part of the larger assessment of compliance with MMC regulations. As of MY 2020, EQR validation protocols for assessing network adequacy had not been published by CMS. Since the publication of the *2020 Medicaid and CHIP Managed Care Final Rule*, OMHSAS is actively reviewing its network adequacy monitoring program to ensure all relevant requirements are covered in the annual validation activity going forward. For behavioral health, those requirements include: quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[23]

Findings

Table 4.1 describes the RY 2020 compliance status of MBH with respect to network adequacy standards that were in effect in 2020. Definitions for most standards may be found in **Section III**, Compliance with Medicaid Managed Care Regulations. The following standards are specific to validation of network adequacy (any substandards for which the MCO is not fully compliant are defined further below):

Standard 11: BH-MCO has conducted orientation for new providers and ongoing training for network.

Standard 59: BM-MCO has implemented public education and prevention programs, including behavioral health educational materials.

Standard 78: 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. e. 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, and Abuse (FWA).

Standard 100: Utilization Management and Quality Management: Provider Satisfaction: The Primary Contractor, either directly or via a BH-MCO or other subcontractor, must have systems and procedures to assess provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual provider satisfaction survey. Areas of the survey must include claims processing, provider relations, credentialing, prior authorization, service management and quality management.

Table 4.1: Compliance with Standards Related to Network Adequacy

Standard Description	Substandard Count	MCO Compliance Status	Primary Contractors	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Standard 1	7	Compliant	All MBH Primary Contractors	1.1, 1.2, 1.4, 1.5, 1.6, 1.7	-	-
Standard 10	3	Compliant	All MBH Primary Contractors	10.1, 10.2, 10.3	-	-
Standard 11	3	Compliant	All MBH Primary Contractors	11.1, 11.2, 11.3	-	-
Standard 23	5	Compliant	All MBH Primary Contractors	23.1, 23.2, 23.3, 23.4, 23.5	-	-
Standard 24	6	Compliant	All MBH Primary Contractors	24.1, 24.2, 24.3, 24.4, 24.5, 24.6	-	-
Standard 59	1	Compliant	All MBH Primary Contractors	59.1	-	-
Standard 78	5	Partial	Bucks, Montgomery (78.5 N/A)	78.1, 78.2, 78.3, 78.4	-	-
			Delaware (78.5 N/A)	78.2, 78.3	78.1	-
			Lehigh, Northampton	78.1, 78.2, 78.3, 78.4, 78.5	-	-
Standard 91	15	Compliant	All MBH Primary Contractors	91.1, 91.2, 91.3, 91.4, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15	-	-
Standard 93	4	Compliant	All MBH Primary Contractors	93.1, 93.2, 93.3, 93.4	-	-
Standard 99	8	Compliant	All MBH Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8	-	-
Standard 100	1	Compliant	All MBH Primary Contractors	100.1	-	-

MCO: managed care organization; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

For this review, 58 substandards were crosswalked to Network Adequacy. All 58 substandards were reviewed for MBH and its Primary Contractors. MBH and these Primary Contractors were compliant with 57 substandards and partially compliant with one.

MBH was partially compliant with Standard 78 due to partial compliance with one substandard.

Standard 78 (see description above)

Substandard 1: Review of County/Corporation management minutes demonstrate actions taken. BH-MCO written notification of key staff changes received within seven days-watch for high turnover, vacant positions.

V: Quality Studies

Objectives

The purpose of this section is to describe quality studies performed in 2020 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the Review Year.[24]

Integrated Community Wellness Centers

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

Description of Data Obtained

Like CCBHC, ICWC features a process measure Dashboard, hosted by the EQRO. Clinics enter monthly, quarterly, and year-to-date (YTD) data into a REDCap project which feeds, on a weekly basis, a server-based Tableau workbook where clinics are able to monitor progress on the implementation of their ICWC model. Using the Dashboard, clinics in 2020 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 Tableau workbook also featured a comparative display that showed clinic and statewide results on each process measure.

Findings

In 2020, the number of individuals receiving at least one core service dropped slightly to just over 17,700 from just over 19,400 in 2019 (the second year of the CCBHC demonstration). The unweighted average (across all the clinics) number of days until initial evaluation was 8 days. In the area of depression screening and follow-up, more than 94% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 3,700 individuals within the ICWC 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 ICWC quality measures are designed to more meaningfully measure the impact of these efforts. Under the CMS-approved ICWC preprint, a subset of the CCBHC measures is reported to CMS on an annual calendar year basis, along with HEDIS Follow-Up After High Intensity Care for Substance Use Disorder (FUI). **Table 5.1** summarizes how well the ICWC clinics did on quality measures compared to applicable performance targets and national benchmarks.

Table 5.1: ICWC Quality Performance Compared to Targets and National Benchmarks

Measure	ICWC Weighted Average	Comparison		
		ICWC 2020 Performance Target	National Benchmark	Benchmark Description
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 7 day	9.9%	N/A (baseline year)	32.45%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 30 day	20.1%	N/A (baseline year)	53.75%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Initiation	74.6%	80.2%	43.0%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Continuation	81.5%	89.6%	54.7%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 7 day	21.5%	26.7%	12.7%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 day	33.7%	38.8%	19.3%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 day	100%	53.4%	39.1%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 day	100%	64.2%	55.2%	HEDIS 2021 Quality Compass 50th percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Initiation	19.0%	28.2%	43.5%	HEDIS 2021 Quality Compass 50th percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Engagement	4.0%	18.8%	14.2%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 7 day	12.0%	30.2%	31.4%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	20.0%	41.6%	52.9%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 7 day	18.1%	43.8%	45.5%	HEDIS 2021 Quality Compass 50th percentile
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 30 day	26.3%	55.6%	70.0%	HEDIS 2021 Quality Compass 50th percentile
Antidepressant Medication Management (AMM) - Acute	58.0%	48.8%	53.6%	HEDIS 2021 Quality Compass 50th percentile
Antidepressant Medication Management (AMM) - Continuation	81.5%	89.5%	45.7%	HEDIS 2021 Quality Compass 50th percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	56.1%	57.3%	62.1%	HEDIS 2021 Quality Compass 50th percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	72.2%	85.0%	82.1%	HEDIS 2021 Quality Compass 50th percentile

Measure	ICWC Weighted Average	Comparison		
		ICWC 2020 Performance Target	National Benchmark	Benchmark Description
Plan All-Cause Readmissions Rate (PCR)	25%	6.9%	9.9%	HEDIS 2021 Quality Compass 50th percentile
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	52.2%	16.2%	17.1%	MIPS 2021 (eCQM)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	39.7%	26.3%	12.2%	MIPS 2021 (eCQM)
Screening for Depression and Follow-Up Plan (CDF-BH)	36.0%	37.7%	50.2%	MIPS 2021 (CQM)
Depression Remission at Twelve Months (DEP-REM-12)	9.4%	N/A	4.9%	MIPS 2021 (eCQM)
Body Mass Index (BMI) Screening and Follow-Up Plan	35.7%	51.0%	49.2%	MIPS 2021 (eCQM)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)	51.0%	64.5%	68.4%	HEDIS 2021 Quality Compass 50th percentile
Tobacco Use: Screening and Cessation Intervention (TSC)	70.5%	56.0%	60.4%	MIPS 2021 (CQM)
Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	69.2%	51.1%	68.4%	MIPS 2021 (CQM)

ICWC: integrated community wellness center; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable; ADHD: attention deficit/hyperactivity disorder; MIPS: Merit-Based Incentive Pay System; eCQM: electronic clinical quality measure; CQM: clinical quality measure.

Quality measures where the ICWC clinics surpassed targets include: FUM, AMM (Acute), PCR, SRA-BH-C, SRA-A, TSC, and ASC.

VI: 2020 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 2021 EQR Technical Report and in the 2021 (MY 2020) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in June 2021. The 2021 EQR Technical Report is the 14th 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, 2021, 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 MCO responses submitted to IPRO in October 2021 to address partial and non-compliant PEPS standards findings, 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 2020 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2020 results, in January 2022. The Root Cause Analysis and Quality Improvement Plan form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed quality improvement plan to address those factors, complete with a timeline of implementation-, monitoring-, and reporting activities. BH-MCOs submitted their responses by March 15, 2022.

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 2019, MBH began to address opportunities for improvement related to compliance categories within the three CMS sections pertaining to compliance with Medicaid Managed Care regulations. Within Compliance with Standards, including Enrollee Rights and Protections, MBH was partially compliant with the following BBA categories: Assurances of adequate capacity and services and Availability of Services. Within Quality assessment and performance improvement program, MBH was partially compliant within the same-named category. Within Compliance with Grievance System, MBH was partially compliant with Grievance and appeal systems. 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 6.1 presents MBH's responses to opportunities for improvement cited by IPRO in the 2021 (MY 2019) EQR Technical Report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.1: MBH's Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year (RY) 2017, RY 2018, and RY 2019 found MBH to be partially compliant with all three sections in CMS Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.		Date(s) of follow-up action(s) taken through 6/30/21/Ongoing/None	Address within each category accordingly.
		Date(s) of future action(s) planned/None	Address within each category accordingly.
MBH 2020.01	Within CMS EQR Protocol 3: Enrollee Rights and Protections Regulations, MBH was partially compliant with two out of nine categories. The partially compliant categories are: 1. Assurances of adequate capacity and services 2. Availability of Services	Date(s) of follow-up action(s) taken through 6/30/21	**Standard 1, Substandard 4: BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).** Magellan has a mechanism in place to address gaps in service and ensure members have timely access to services. See Magellan's Identification of Network Capacity and Gaps in Services Procedure. Gaps in network are reviewed in various County quality oversight committees.
		Date(s) of follow-up action(s) taken through 6/30/21	**Standard 1, Substandard 7: Confirm FQHC providers.** Magellan is contracted with FQHC providers in all Counties.
		Date(s) of follow-up action(s) taken through 6/30/21	**Standard 23, Substandard 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.)** The Written Translation report was updated in 2020 to include a breakdown by County of request.
MBH 2020.02	Within CMS EQR Protocol 3: Quality Assessment and Performance Improvement Regulations, MBH was partially compliant with quality assessment and performance improvement program.	Date(s) of follow-up action taken through 6/30/21	**Standard 91, 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).** 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 with the

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			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 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.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Clinical Coordination Rounds are available across contracts but occur specifically with Lehigh/Northampton Wellness Recovery Teams (WRT). Magellan supports cross system collaboration to be offered quarterly, or as needed. Magellan collaborates with Gateway and Health Partners for the Emergency Department (ED) Data Exchange Pilot which is an initiative to share emergency department data for the purpose of analysis, member outreach opportunities, and identifying trends among BH providers and/or ED providers. As noted in the 2020 Magellan Behavioral Health of Pennsylvania, Inc. Quality Improvement – Clinical Management Program Evaluation: • Magellan participated in PHMCO-BHMCO Coordination Meetings to collaborate, coordinate, and share best practices throughout 2020. Magellan attended 100% of the quarterly Lehigh/Capital Region PH/BH MCO coordination meetings as well as the quarterly Southeast HealthChoices Behavioral Health/Physical Health meetings, for which Magellan's Director of Integrated Health served as Chair in 2019 and 2020. • Magellan maintained clinical coordination rounds with AmeriHealth and Gateway in combination with the community-based provider WRTs. Rounds occurred quarterly and included the WRT, AmeriHealth or Gateway representation, and Magellan. The goal is to decrease fragmented care and remove barriers to access. Referral opportunities are discussed as well as any follow up actions needed by any party in attendance to improve member supports. • Magellan also had a shared goal with Gateway and Health Partners PH-MCOs that focused on an initiative to share emergency department (ED) utilization data for the purpose of analysis, member outreach opportunities, and identifying trends among BH providers and ED providers. Data was shared quarterly, through a data exchange process. A total of 307 outreach efforts were made including a total of 282 members to offer community resources and education on mobile crisis supports to reduce emergency room utilization. While the detailed outcome of individual calls is not available, feedback from the teams included that many members were unable to be reached and of those who were reached, many reported their main reason for going to the ED was for a physical health need and not a behavioral health need. Interventions with this data will be focused on reducing Emergency

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Department Utilization, increasing utilization of mobile crisis supports, and this activity will be monitored under the Quality Program Quarterly Monitoring (see under Quality Measures/HEDIS). In partnership with the PH-MCOs, it was decided that this intervention would not be continued into 2021 due to barriers in reaching members and limited impact from 2019/2020 efforts. • Magellan partnered with Health Partners Plans (HPP) and completed 145 reviews in 2020. • Magellan partnered with Keystone First to review members enrolled in Keystone's maternity care management program who also have a Serious Mental Illness diagnosis; 151 reviews were completed in 2020. • Magellan and Aetna aimed to implement a texting initiative in which members who went to the ED with a behavioral health diagnosis tied to their claim would be texted, through Aetna's texting system, providing contact information for Magellan. This program was developed throughout the year and was implemented mid-October. Of those who received the text, 8.18% chose to opt-in to receive Magellan's information, which reflects 7 members. Discussions with Aetna in Q4 included modifying their logic to include a larger number of members who may receive the texts. A second joint goal included increasing ICP counts in 2020 as compared to 2019 counts. This goal was met with 243 reviews completed in 2020 versus the 202 that were completed in 2019. The last joint goal was to implement reviews of Aetna's maternity members who had a qualifying Serious Mental Illness diagnosis. Rounds were implemented in 2020 with a total of 55 maternity members reviewed. • Magellan partnered with UPMC and completed 94 reviews in 2020. • Magellan attended all CHC regional quarterly meetings and was the host for one of the four meetings. The meetings were held on 3/24/20, 6/25/20, 9/23/20, and 12/16/20. Magellan led the September CHC Partners meeting which provided a presentation on behavioral health supports which included levels of cares available and how to access that care. • Clinical care coordination meetings occur routinely, most often weekly, and included opportunities for unique member case reviews. Magellan worked towards developing and implementing a routine file exchange process with CHC MCOs, which was finalized in 2020. • Magellan provides the CHC MCOs with information on inpatient admissions, and further supports the data sharing for this population with weekly clinical review calls to discuss admissions and discharges for the week. Magellan also

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			helped to further support the CHC population through Magellan's CHC Care Managers outreach to WRTs and Nurse Navigator programs in the community to educate on CHC supports and offer assistance in obtaining support from the CHC MCOs.
		Date(s) of future action planned- Ongoing	Magellan will continue to participate in the quarterly Lehigh/Capital Region and Southeast HealthChoices Behavioral Health/Physical Health coordination meetings in 2021. Magellan will continue collaboration efforts with other MCOs and other entities in 2021.
		Date(s) of follow-up action taken through 6/30/21	**Standard 91, Substandard 6: The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.** 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 the PA Incompetency to

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			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. • As noted in the 2019 Magellan Behavioral Health of Pennsylvania, Inc. Quality Management-Clinical Management Program Evaluation approved by OMHSAS in May 2020: • Magellan participates in a project called Bucks County Connect Assess Refer Engage Support (BCARES). This is a warm handoff collaboration between the six hospital emergency departments and an assigned certified recovery specialist (CRS) for individuals who have survived an opioid overdose. Survivors are offered a direct connection from the emergency department to treatment and recovery support services. Magellan supports the County's initiative through marketing, training, etc. • Magellan partners as a key participant in the Cambria County Suicide Prevention Task Force. This joint collaborative effort includes participation in monthly Task Force meetings and regular sub-committee meetings (Training & Education, Out of the Darkness Walk Committee, Fundraising, Marketing/Publicity and Loss Survivor Resources). Trainings on Suicide

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Prevention were provided with over 250 people trained in 2019. Training topics included: Mental Health First Aid (Adult and Youth), Question Persuade and Refer: QPR Suicide Gatekeeper Training, and safeTALK – Suicide Awareness Training. • Collaborative efforts in Delaware County focused on maintaining a Meeting Collaborative on Behavioral Health Supports. This involved participation and representatives from several organizations. Major accomplishments of the efforts included development of strong relationships with system partners, improved identification of members with behavioral health needs, use of screening tools in the schools, and increased referrals to behavioral health services. • Magellan has extensive experience collaborating with school districts and other affected agencies and stakeholder organizations to implement school-based mental health programs. Most recently in 2019, Magellan collaborated with all the school districts in Lehigh and Northampton Counties to review access to mental health services within each district. The collaboration identified that over 80% of children referred for a mental health assessment as part of the Student Assistance Program (SAP) met criteria for outpatient counseling. This high rate led to identification of needing enhanced partnerships with schools and co-locating additional outpatient mental health treatment in the school settings. By working with the school and community mental health providers, offering technical assistance in setting up satellite sites in the schools resulted in 40 new school-based clinic sites. This collaboration also resulted in: • Initiation of the Lehigh Valley School Mental Health Collaborative using of the University of Washington Collaborative Care in School model, an innovative approach to integrated mental health service delivery that focuses on reducing access barriers through: enhancing community partnerships, increasing service accessibility, integrating mental health, primary care, and educational providers and services, and improving service quality through increased use of evidence based practices by school-based practitioners. • Partnership with the United Way of Lehigh Valley in the Handle With Care program of enhanced police-school communication to better support students exposed to traumatic events and support the implementation of trauma informed school practices, including discussion on use of the Safe2Say system for Handle With Care referrals to match school protocols. • One school district integration of SAP and mental health assessment into the

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			Multi-Tiered Support Structure (MTSS) framework, a three-tiered, schoolwide approach that promotes early identification and support of students with learning and emotional/behavior needs, to improve access to the school based mental health services. • In 2019 collaborative efforts for Montgomery County involved coordination with the criminal justice system. Magellan maintained participation in the "Stepping Up Committee" alongside Montgomery County BH staff and HealthChoices Staff, Montgomery County Public Defenders, District Attorney, Adult Probation, the Correctional Facility, Behavioral Health providers, Drug Court, Behavioral Health Court, Homeless Services, the Montgomery County Housing Department, the Regional SCI Coordinator and Information Technology staff. Key accomplishments were noted to be development of stronger relationships with system partners, improved identification of members with SMI/SA who are currently incarcerated, ability to offer outpatient assessments to incarcerated members via telehealth thorough grant funds to help successfully divert individuals from incarceration. • Recommendations for the 2020 Quality Work Plan were discussed during the 10/24/19 QIC meeting. The Work Plan objective for 2020 was updated to: Magellan will focus on formalized collaborative efforts to be conducted with organizations such as schools, state and local police and other community agencies. The Work Plan goal for 2020 was: Magellan participates in collaborative efforts within each contracted county. • The 2021 Clinical-Quality Improvement Workplan was submitted to OMHSAS on 2/28/21, included county level detail within the relevant workplan indicator. The focus of these projects across counties this year will be forensic-related projects. As noted in the 2020 Magellan Behavioral Health of Pennsylvania, Inc. Quality Management-Clinical Management Program Evaluation: Magellan has collaborated with organizations across all contracted counties, such as schools, state and local police, and other community agencies throughout 2020. These efforts varied in activity by contract, but a minimum of one activity was maintained per county with efforts lead by that contract's respective Account Executive. • In Bucks County, Magellan's participation in a project called Bucks County Connect Assess Refer Engage Support (BCARES) expanded in 2020. This is a warm handoff collaboration between the six hospital emergency departments and an assigned Certified Recovery Specialist (CRS) for individuals who have

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			survived an opioid overdose. Survivors are offered a direct connection from the emergency department to treatment and recovery support services. BCARES will also serve individuals with a substance use disorder who are being treated in one of the six Bucks County Hospital Emergency Departments or who were admitted to other units within those hospitals. The CRS will provide recovery support, education, resources and treatment options. Families and significant others are also provided with support and resources. • Magellan supports the BPAIRS project, Bucks County Police Assisting in Recovery. There are currently 18 police departments participating in BPAIRS. Through this program, if an individual goes to a police department, a volunteer will assist in getting them connected to treatment. At Bensalem, they get a video assessment from Gaudenzia. Magellan supports the county's initiative in various ways including marketing, training, etc. Magellan will continue our participation through the duration of the project, which extends into the 2021 calendar year. The goals for 2021 remain the same and will be routinely evaluated. • In Cambria County, Magellan partners as a key participant in the Cambria County Suicide Prevention Task Force. This joint collaborative effort includes participation in monthly Task Force meetings and regular sub-committee meetings (Training & Education, Out of the Darkness Walk Committee, Outreach, Fundraising, Marketing/Publicity and Loss Survivor Resources). Due to the COVID-19 pandemic, the Task Force had to switch to virtual meetings and events, beginning in March 2020. The Out of the Darkness Walk was held virtually for the first time. Trainings offered were Adult and Youth Mental Health First Aid and Question, Persuade and Refer (QPR) Training. ➢ The Task Force promoted a Self-Care Fair at the Galleria Mall in Johnstown (Cambria County) in February, right before the Pandemic caused businesses and schools to close. This event was a great success and will be held again in the future. This collaboration will continue as it is felt that the work of the Task Force is critical to helping prevent suicides in Cambria County. • Collaborative efforts in Delaware County focused on maintaining a Meeting Collaborative on Behavioral Health Supports in school settings. This involved participation and representatives from several organizations to include Magellan staff, The Delaware County Intermediate Unit, Crozer (a Network provider), and Delaware County Office of Behavioral Health staff. Major accomplishments of the efforts included development of strong relationships with system partners, improved identification of members with behavioral

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			health needs, use of screening tools in the schools, and increased referrals to behavioral health services. • In 2020, challenges included adapting supports to accommodate for remote learning. Some families/students did not have internet service or technology for remote learning. Some families also needed additional support for food and other social determinant of health needs. Behavioral health supports were provided virtually for students that needed additional help. In September, DCIU and Crozer transitioned back to in person learning/services for those families that wanted to have their children in school. Behavioral health supports were provided virtually and in person for students. ➢ Participants of the Collaborative felt that objectives were met for 2020 and plan to continue participation for 2021. The plan is to meet quarterly in 2021. • Magellan's School-Based Mental Health (SBMH) initiative in Lehigh and Northampton counties expands access to professional, licensed, outpatient mental health services co-located within public school buildings for students and families covered by Medicaid. Over 80 clinics were developed and are co-located within school settings. The initiative further integrates Student Assistance Program (SAP) and mental health assessment into the Multi-Tiered Support Structure (MTSS) framework, a three-tiered, schoolwide approach that promotes early identification and support of students with learning and emotional/behavioral needs, to improve access to the school based mental health services. The services and partnership developed with schools is further supported by Letters of Mutual Cooperation Agreements offered to school districts. The Allentown School District desires to formally execute this agreement and is being reviewed by the school board for final approval in 2021. Specific collaborations included: ➢ In January 2020, a Learning Community was created to guide best practices, target care, and improve the protective factors of students in need. School district administration, treatment providers, county human services departments and Magellan met monthly with providers, county, provider agency, and other nonprofit stakeholders to coordinate and improve services to the Medicaid-eligible families we serve. ➢ The Lehigh Valley School Mental Health Collaborative follows the University of Washington Collaborative Care in School model, an innovative approach to integrated mental health service delivery that focuses on reducing access barriers through: enhancing community partnerships, increasing service accessibility, integrating mental health, primary care, and educational providers and services, and improving service quality through increased use of

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			evidence based practices by school-based practitioners. ➢ Partnership with the United Way of Lehigh Valley in the Handle With Care program of enhanced police-school communication to better support students exposed to traumatic events and support the implementation of trauma informed school practices, including discussion on use of the Safe2Say system for Handle With Care referrals to match school protocols. ➢ Other collaborative agreements and strategies undertaken in the Lehigh Valley during 2020, also include a joint training with Pennsylvania 2-1-1. The scope of this project included Pennsylvania 2-1-1 resource counselors and Magellan Behavioral Health of Pennsylvania, Inc. care managers sharing trended information on Social Determinants of Health (SDoH) factors, data collection, and the referrals and tools used to help individuals with a SDoH need. These efforts are complemented by integrated health initiatives, provider learning community approaches to better population health, and an emphasis on including new quality metrics for member and family satisfaction surveys, and value-based approaches to care delivery systems for social determinants of health need. • In 2020, collaborative efforts for Montgomery County involved coordination with the criminal justice systems through the Stepping Up Initiative. Magellan actively participated in the Stepping Up Steering Committee in partnership with Montgomery County Behavioral Health staff, Montgomery County Public Defender's Office, the District Attorney, Montgomery County Correctional Facility, Adult probation and parole, behavioral health providers, advocacy organizations, regional forensics, county housing team members, homeless services and information technology. Key accomplishments for 2020 include: increased collaboration between systems, increased coordination of care for forensic members, increase in access to care for members, ability to offer behavioral health intake assessments to members who are incarcerated at Montgomery County Correctional Facility (MCCF), suicide prevention assessment at MCCF and Mental Health Procedures Act training for police and forensic providers.
		Date(s) of future action planned- Ongoing	The joint collaborative studies reported upon in this section for each contract are all extending into the 2021 calendar year. However, Magellan intends to take a systemic review in the coming year to assess opportunities to support forensic treatment needs within the HealthChoices delivery system. While in each contracted county the activity may be structured differently to meet the unique needs of that area, Magellan strives to find additional avenues to have meaningful engagement and influence as a system partner in the communities for whom we serve as part of the joint

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			collaborative studies effort.
		Date(s) of follow-up action taken through 6/30/21	**Standard 91, 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.** 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. Recommendations for the 2020 Quality Work Plan were discussed during the 10/24/19 QIC meeting. The 2020 objective is: Treatment Record Reviews (TRRs) will be utilized to monitor documentation practices against policies/procedures; findings of TRRs will be shared with providers. The 2020 goal was: Results are expected to be >85%. Providers with TRR activities not meeting the targeted goal will be addressed via action plan resolution. As noted in the 2020 Magellan Behavioral Health of Pennsylvania, Inc. Quality Management-Clinical Management Program Evaluation, Magellan developed a schedule of Treatment Record Reviews (TRRs) of specifically identified levels of care/service types for routine oversight activities utilizing a statistically valid random sample from network providers. The number of programs selected was based on an analysis of prior audits conducted. Integrated Audits were conducted based on the level of care being reviewed. In addition to Routine Integrated Audits, several other audit types are conducted, to

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			ensure that providers meet or exceed quality standards set forth by Magellan. Applicable levels of care tools and Clinical Practice Guidelines tools were used as appropriate. Providers who did not meet or exceed standards were requested to submit an action plan: • Routine Clinical Audits: These audits are conducted based on the utilization of a statistically valid random sample of network providers. In measurement year 2020, there was one (1) such audit completed. • Integrated Audits (IA): These audits are conducted based on the level of care being reviewed and include both a clinical and claims review. In measurement year 2020, there were sixty-two (62) such audits completed. • Targeted Integrated Audits: These audits are conducted when a particular concern arises that warrants both a clinical and claims audit be conducted outside of the re-credentialing process. In measurement year 2020, there were twelve (12) such audits conducted. • Integrated Follow-up Audits: These are audits conducted to assess the implementation of Action Plans and further clinical review and claims screenings. There were four (4) such audits completed in 2020. • Implementation Oversight Audits: These audits are conducted approximately ninety (90) days following the start of a new program, to assess a program's adherence to the Program Description, applicable regulations, clinical, compliance and network expectations. Thirty-six (36) such audits were conducted in 2020.
		Date(s) of future action planned- Ongoing	Treatment Record Reviews include review of individualized treatment planning and the quality of those plans. This scoring is a variable reported in the overall scoring of the treatment record review.
		Date(s) of follow-up action taken through 6/30/21	**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 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 • Telephone Contact with Magellan Health • Reimbursement Issues (e.g. claims processing)

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			• Credentialing • Communication • Compared to Other Managed Care Companies • Provider Training • Inquiry if the provider has interest in Magellan providing any specific topics of trainings Provider satisfaction findings are analyzed and included in the Magellan Behavioral Health of Pennsylvania Inc., Clinical-Quality Annual Program Evaluation on pp. 200-205. This review includes all survey questions that were asked of providers as well a comparison to prior years. As a new survey instrument was used, Magellan is regarding 2019 provider satisfaction rates as a new baseline. Recommendations for the 2020 Quality Work Plan were discussed during the 10/24/19 QIC meeting. The 2020 objective is: Overall experience (satisfaction) with Magellan will be reported upon annually. The 2020 goal is: The annual Provider Experience report should include review of all areas of survey focus, provide a comparison of results to prior years' findings, in order to assess for areas of opportunity. Analysis should identify program strengths and opportunities. Improvement opportunities will be supported through Committee oversight. As noted in the 2020 Magellan Behavioral Health of Pennsylvania, Inc. Quality Management-Clinical Management Program Evaluation, Magellan surveys its participating network providers annually to obtain their perceptions of the service they received in collaborations with Magellan. Feedback is collected using the Magellan Provider Experience Survey designed and administered by Magellan's Experience Analytics Team. Actively contracted providers were eligible to participate in the survey. Initial email contact about the survey describes the purpose, length of time needed to complete the survey, and privacy protections. Reminder emails about the survey are sent at designated time periods, as necessary during the data collection period. Data collection closes approximately four weeks after initial emails are sent, or after the necessary sample size is achieved, whichever is earlier. The 2020 provider satisfaction results as they compare to 2019 can be found on pages 302 through 306 of the 2020 Magellan Behavioral Health of Pennsylvania, Inc. Quality Management-Clinical Management Program Evaluation.
		Date(s) of future action	Magellan has enhanced the Quality Work Plan to include specificity for provider

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
		planned- Ongoing	experience and areas of survey focus and benchmarks from the previous review period in order to assess progress.
		Date(s) of follow-up action taken through 6/30/21	**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.** The recommendation for the 2020 Quality Work Plan to include information on how previously issued Corrective Action Plans (CAP) are addressed was discussed during the 10/24/19 QIC meeting. As a result, a Work Plan item was added focusing on the monitoring of CAP activities. The 2020 Work Plan objective is: Magellan will address all corrective action plans (CAPs) issued by oversight agencies in a timely manner. The 2020 Work Plan goal is: Magellan will maintain compliance with regulatory requirements and Program Standards and Requirements. In 2020, Magellan addressed all CAPs issued by oversight agencies in a timely manner. Details can be found on pages 374 and 375 of the 2020 Magellan Behavioral Health of Pennsylvania, Inc. Quality Management-Clinical Management Program Evaluation.
MBH 2020.03	Within CMS EQR Protocol 3: Compliance with Grievance System, MBH was partially compliant with grievance and appeal systems.	Date(s) of follow-up action taken through 6/30/21	**Standard 68.1, Substandard 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.** Magellan conducts a Member Complaints Training for Magellan staff annually. The Member Complaint Investigation and Decision Making Training is also conducted for Magellan staff annually. In 2019, the annual Member Complaints Training was held on 7/10/19. In 2020, the Member Complaints Training was held on 7/22/20. In 2021, the Member Complaints Training was held on 4/14/21. In 2019, the Member Complaint Investigation and Decision Making Training was held on 1/30/2019. In 2020, the Member Complaint Investigation and Decision Making Training was held on 2/12/20.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
			In 2021, the Member Complaint Investigation and Decision Making Training was held on 2/17/21.
		Date(s) of follow-up action taken through 6/30/21	**Standard 71.1, Substandard 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.** Magellan conducts a Member Grievances Training for Magellan staff annually. In 2019, the annual Grievances Refresher Training was held on 7/24/19. In 2020, the annual Grievances Refresher Training was held on 8/12/20. In 2021, the annual Grievances Refresher Training was held on 3/31/21.

MBH: Magellan Behavioral Health; MCO: managed care organization; RY: reporting year; BH: behavioral health; PS&R: Program Standards and Requirements; PEPS: Program Evaluation Performance Summary; CAP: corrective action plan; QI: quality improvement; QM: quality management; CQI: continuous quality improvement; LGBTQI: lesbian, gay, transgender, queer/questioning, intersex; OMHSAS: Office of Mental Health and Substance Abuse Services; SA: substance abuse.

Root Cause Analysis and Quality Improvement Plan

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

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

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

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

Instead, in late 2020, MY 2019 results were calculated and compared to the MY 2019 goals to determine RCA and QIP assignments, along with goals, for MY 2021. In MY 2020, MBH scored below the 75th percentile on both the 7- and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. **Table 6.2 and Table 6.3** present MBH's submission of its RCA and QIP for the FUH All-Ages 7-day and 30-day measures, respectively. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.2: MBH RCA and QIP for the FUH 7–Day Measure (All Ages)

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): As in previous years, Magellan examined the 7-Day FUH data by first breaking it down by demographic factors to determine which factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, race, and ethnicity. The data in the State's Tableau database was examined via "head-to-head" comparisons between populations. Special attention was given to identifying disparities related to race, comparing FUH rates for the White subpopulation with the FUH rates for each non-White race group. Magellan examined differences in FUH rates related to ethnicity via the head-to-head comparison for the Hispanic and non-Hispanic populations. Magellan also sought input on barriers to FUH by re-surveying inpatient providers with a survey similar to that which was administered last year, in order to identify any changes in barriers identified. This provider 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 2022"). Magellan decided to combine a few causal factors into "bundles" of causal factors, because the interventions planned would address the whole bundle and not just each single factor. 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. Extra attention centered on how to address identified disparities related to race and ethnicity. Please see the attachment "RCA 7-day FUH MY2020" for details and results of this analysis.	***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** Please refer to Magellan's root cause analysis, in this embedded document: Click here for the Ishikawa fishbone diagram of the root cause analysis conclusions: Below are several Logic Models of Change for Magellan's major interventions:
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***
People (1)	***Causal Role (relationship to other factors and to the overall performance indicator)***

<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td rowspan="2">Co-Occurring Disorders
• Substance use relapse
• SUD not sufficiently addressed</td><td>and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
This factor can independently impact FUH rates and can also interact with other factors to impact FUH rates, so the causal role is critical. The causal weight for this factor is also critical, considering the quantitative (FUH rates for people with co-occurring disorders) and qualitative findings (member and provider opinions).</td></tr>
<tr><td>Current and expected actionability: High
Magellan continues to see multiple opportunities to continue and enhance existing interventions targeting this factor.</td></tr>
<tr><td rowspan="2">People (2)
Member chooses to not pursue treatment
• Past negative experiences with treatment
• Believe they do not need treatment (at precontemplation stage)</td><td>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 change, or if they have minimal insight about their illness then, in their view, they do not need treatment. Also, past negative experiences with treatment, even poor customer service from providers, can cause trauma, and result in avoidance of similar situations in the future.</td></tr>
<tr><td>Current and expected actionability: Moderate
Magellan has already made some impact on improving the customer service of outpatient providers, by bringing the results of the Front-End Customer Service Assessment to their attention. Magellan hosted a training on intervening with Precontemplation last year, but no inpatient providers attended. The feedback from the attendees was very positive and they reported that they were able to use new skills with individuals who were at the precontemplation stage, so it is expected that inpatient providers could benefit from similar training.</td></tr>
<tr><td>People (3)
Member-specific demographic factors
• Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH
• Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who are Black/ African American show lower FUH rates than members who identify as white).
• Member speaks a language other than English</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Factors related to a member demographics, including socioeconomic status, interact with other factors to have an unknown causal role in low follow-up rates. For example, a person’s race per se may not directly affect the person’s ability and willingness to attend follow-up care, but SDoH factors related to socioeconomic status, which can impact some races more than others, can result in a disparate impact on follow-up. There may also be variation in the degree that people of different sub-groups feel “welcome” in treatment, perhaps due to past experiences with discrimination or related to a need for improvement in provider cultural competency. The true causal role is unknown. There were a few reports from</td></tr>
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<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td></td><td>inpatient providers about language being a barrier, but this has not appeared in Magellan's data. However, when a person uses a language other than English, this can be a very important barrier in that one case.</td></tr>
<tr><td></td><td>Current and expected actionability: Moderate, but indirect
While Magellan cannot directly mitigate or eliminate disparities that are related to race, ethnicity, socioeconomic status, and SDoH, Magellan can encourage that such factors are addressed in all discharge planning discussions, so that individualized planning can occur to address strengths and barriers that are affecting the individual member. In the rare cases in which a member needs follow-up care in a language other than English, this can be considered "very" actionable.</td></tr>
<tr><td>People (4)

• Member is not comfortable with telehealth</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
This factor is considered separate from whether a person has the technology to use telehealth. This factor can also combine with other barriers to decrease the chances of attending follow-up care. Data reveals that this factor is present in a minority of members, but when it is present, it is important.</td></tr>
<tr><td></td><td>Current and expected actionability: Moderate
Personal discomfort with telehealth can be identified during a hospital stay, and steps can be taken to set up in-person services for follow-up care. If the reason for discomfort is lack of familiarity, perhaps this can be addressed during the person's inpatient stay. But if the discomfort is due to a more persistent factor such as paranoia, this would be much less actionable. Due to other factors like lack of provider staff availability and quarantine needs, there may be instances in which only telehealth is available at a given time.</td></tr>
<tr><td>Providers (1)
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
• Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process
• Not involving the member's support system in discharge/aftercare planning</td><td>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 continues to be critical, as inadequate discharge planning, especially when discharge plans do not address all individual barriers to follow-up care, is likely to result in lower FUH rates. Any lack of involvement of the person's support system in aftercare planning can further decrease the chances of attending follow-up care. Therefore, attention to including existing collaterals, as referring to additional collaterals is essential.</td></tr>
<tr><td></td><td>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</td></tr>
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<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td></td><td>bar" in our expectations of inpatient providers, as well as on Magellan's own care management team, to continue to incorporate (and enhance) Project Re-Engineered Discharge (RED) informed discharge planning components, to ensure full member input into discharge planning, to address or plan for all SDoH barriers that are affecting the individual, and to consider all cultural factors that might be associated with higher or lower follow-up rates. Magellan considers race, ethnicity, and language as cultural considerations, but also individual factors like religion, and LGBTQIA status. Additional expectations around including existing collaterals in discharge planning can be implemented, as well as referring to additional collateral supports.</td></tr>
<tr><td rowspan="2">Providers (2)
"The Philadelphia Factor"
Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals
Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties
Philadelphia hospitals may benefit from additional guidance about best practices in discharge planning
When a member is homeless, Philadelphia hospitals refer them to a Philadelphia shelter (may be the only option temporarily) and a nearby behavioral health provider in Philadelphia</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Analysis of FUH data by hospital location and discussion with Magellan's Clinical team has revealed that "the Philadelphia Factor" may have an important role in FUH rates. It was concluded that being discharged from a hospital in Philadelphia, as opposed to elsewhere, is an important factor associated with lower FUH rates. In addition to impacting Magellan members, this factor also appears to impact HealthChoices members who reside in Philadelphia.</td></tr>
<tr><td>Current and expected actionability: Moderate
Magellan is identifying opportunities to enhance discharge planning contacts with Philadelphia-based hospitals in a way that will better identify resources and barriers to follow-up in the member's home county, as well as special planning for members who are temporarily homeless and must be temporarily placed in Philadelphia. However, there has not been sufficient buy-in from Philadelphia hospitals, largely because Magellan members only constitute a small portion of the people they see.</td></tr>
<tr><td rowspan="2">Providers (3)
Outpatient provider availability
Lack of psychiatrist time overall
Providers not offering openings within seven days
Compounded by recent staffing shortages</td><td>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 versions of this RCA. But since the pandemic, and post-pandemic economic changes, there have been significant challenges with provider staffing. This is a critical issue affecting providers of all levels of care.</td></tr>
<tr><td>Current and expected actionability: Moderate/Low
During concurrent reviews, additional focus can be given to identifying an outpatient follow-up provider and setting up the appointment earlier in the member's stay,</td></tr>
</table>

<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td></td><td>rather than waiting until the final days of the hospital stay. This way, hospitals can alert Magellan when they are having difficulty finding an available follow-up provider. The staffing shortage, however, is a less actionable factor, as this is occurring not only in behavioral health, but in other industries as well, and across the nation. Magellan can attempt to support providers in their recruitment and retention efforts, such as with stabilization funding.</td></tr>
<tr><td rowspan="2">Policies / Procedures (1)
Inadequate identification of members at higher risk of not attending follow-up care and what the next steps should be</td><td>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. The causal weight of this factor is important. It is also critical that hospitals and Care Managers know what to do next, once they have identified a member as being at higher risk for not attending follow-up care.</td></tr>
<tr><td>Current and expected actionability: Moderate
Magellan attempted to address this by creating a tool based on internal and external data, to help Care Managers and providers identify who may be at higher risk of not attending follow-up. There is still an opportunity to increase the use of this tool, and improve what is done, once a member is identified as being at higher risk.</td></tr>
<tr><td rowspan="2">Policies / Procedures (2)
Open Access/Walk-In Intakes
Some outpatient providers will only offer open access
Some outpatient providers will only offer intake appointments in the very early morning.</td><td>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 used to be more prevalent than it is at present. Magellan has had prompt communication with outpatient providers every time this issue was reported, and as a result, the frequency with which this barrier occurs has decreased substantially. However, Magellan will continue to keep a close eye on this a “somewhat important,” as it is very possible that it could increase again as provider continue to experience staffing challenges.</td></tr>
<tr><td>Current and expected actionability: High
Magellan has already proven that this issue is highly actionable, as when leadership at outpatient organizations are reminded about Magellan’s expectation, they have taken this seriously.</td></tr>
<tr><td>Policies / Procedures (3)
Outpatient Provider Responsiveness
Lack of timely response to calls/ referrals from inpatient providers
Lack of timely response to calls from members
Lack of afternoon, evening and weekend appointments for</td><td>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 lack of provider responsiveness is assessed to be critical. Magellan initiated a multi-year customer service assessment with the largest volume outpatient providers, and this continues into 2022. The issue with a limited late day, evening, and weekend intake appointments has an important causal role, but the</td></tr>
</table>

<table>
<tr><th colspan="2">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td rowspan="2">intake</td><td>staffing challenges experienced by most providers since the pandemic can result in this becoming critical.</td></tr>
<tr><td>Current and expected actionability: Mixed
The actionability for addressing provider customer service and answering telephones is high. The actionability for hours of operation expanding to evening and weekend hours is low at present.
Magellan plans to continue and enhance the customer service assessment effort, with aggregate reports, and individual provider reports. As long as there is a behavioral health staffing shortage, expanding evening and weekend hours may not be a possibility for most providers.</td></tr>
<tr><td rowspan="2">Policies / Procedures (4)
Quarantining policies & procedures
• Inpatient providers- quarantining on AIP unit
• Outpatient providers- when member tests positive after discharge but before FUH visit</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
The need to quarantine when testing positive for COVID is a new issue, and the causal role in follow-up rates is still unknown. The hypothesis is that spending time in quarantine in an inpatient unit creates a qualitatively different type of hospital experience. When a member tests positive for COVID after discharge, but before the follow-up appointment, this could have a critical impact on the ability to attend the appointment.</td></tr>
<tr><td>Current and expected actionability: Moderate
With cases in which the member is assigned to a Community Transition Coordinator or Peer support provider, this may be highly actionable, as the support person could promptly help the member transition to a telehealth appointment or another alternative as soon as they learn that the member has tested positive for COVID. In cases that appear more “routine” at the time of discharge, the actionability would be lower.</td></tr>
<tr><td rowspan="2">Provisions (1)
Lack of Transportation,
Lack of knowledge of transportation resources</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Lack of transportation has been identified every year as having an important role in follow-up rates. Transportation is considered under the umbrella of Social Determinants of Health (SDoH), but it is important enough to warrant its own attention in this QIP. This year the related factor of providers and members lacking knowledge about transportation resources was added. These factors appear to have an important causal role resulting in lower follow-up rates.</td></tr>
<tr><td>Current and expected actionability: Mixed
Ensuring that a member actually has transportation for the follow-up visit may be difficult, considering the time it might take to enroll in MATP, or limitations on</td></tr>
</table>

<table>
<tr><th colspan="4">RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)</th></tr>
<tr><td colspan="2"></td><td colspan="2">scheduling with MATP providers. But the actionability of increasing knowledge of these resources and how to enroll is highly actionable.</td></tr>
<tr><td colspan="2" rowspan="2">Provisions (2)
Member lack of technology to make use of telehealth</td><td colspan="2">Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):
Technology resources are also considered an SDoH factor that can have an important impact on attending follow-up care if the appointment is via telehealth. As mentioned above with transportation, this SDoH factor is separate and important enough to warrant separate attention in this QIP.</td></tr>
<tr><td colspan="2">Current and expected actionability: Moderate
If an assessment of resources and barriers related to technology were to become a routine part of discharge discussions, this factor can be highly actionable. In cases where a member does not possess the technology, they can instead pursue an in-person appointment if available or initiate an application for a subsidized smart phone. However, in the current climate of staffing shortages, finding alternative in-person appointments may pose a difficulty. Also, the length of time it takes to apply for and eventually receive a subsidized smart phone could prove to be a barrier itself.</td></tr>
<tr><th colspan="4">Quality Improvement Plan for CY 2022</th></tr>
<tr><td colspan="4">Rate Goal for 2022 (State the 2022 rate goal from your MY2020 FUH Goal Report here): 7-Day FUH Goal 39.18%</td></tr>
<tr><td colspan="4">The factors above can be thought of as barriers to improvement. <u>For each barrier</u> identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2021 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.</td></tr>
<tr><td><u>Barrier</u></td><td><u>Action</u> Include those planned as well as already implemented.</td><td><u>Implementation Date</u>
Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)</td><td><u>Monitoring Plan</u>
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.</td></tr>
<tr><td>People (1)
Co-Occurring Disorders
• Substance use relapse
• SUD not sufficiently</td><td>Magellan’s Co-Occurring Competence Efforts—Internal Training/Coaching</td><td>2/2021 and ongoing</td><td>Will monitor:
--Frequency of trainings and mentoring sessions
--Co-Occurring Disorder subject matter expert attends monthly Acute Inpatient Rounds, and has weekly “office hours” mentoring with Care</td></tr>
</table>

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
addressed	**Incentivizing co-occurring competence among outpatient providers (Also a PIP intervention)**	7/2021 and ongoing	Managers This effort is monitored via Magellan's Performance Improvement Project (PIP) effort and reported quarterly to OMHSAS and IPRO.
People (2) ***Member chooses to not pursue treatment*** • ***Past negative experiences with treatment*** • ***Believe they do not need treatment (at precontemplation stage)***	**Front End Customer Service Assessments of Outpatient Providers** **Training for Providers on Precontemplation**	9/2020 and ongoing 4/28/2022	Calls will be made Q2 and Q3 of 2022, followed by an aggregate report and individualized reports to providers, with improvement recommendations. This is part of Magellan's Motivational Interviewing Training Series, mostly attended by SUD providers. Will track how many acute inpatient providers attend this session.
People (3) ***Member-specific demographic factors*** • ***Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH*** • ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who are Black/ African American show lower FUH rates than members who identify as white).*** • ***Member speaks a***	**Include discussion of cultural factors in discharge planning** **Include discussion of SDoH factors that can impact FUH in all discharge planning discussions** **Ensure that when member prefers a language other than English that this is addressed in planning follow-up care**	Q2 2022 3/2021 and ongoing. New audit to start Q2 2022 New audit to start Q2 2022. New electronic health record anticipated to start Q3 2022.	A sample of discharge notes will be audited monthly by the QI team for inclusion of the consideration of cultural factors in discharge planning. Feedback will be provided to the Acute Inpatient Care Managers monthly. A sample of discharge notes will be audited monthly by the QI team for inclusion of the consideration of SDoH in discharge planning. Feedback will be provided to the Acute Inpatient Care Managers monthly. Magellan's new clinical electronic health record is in the development stage, and reports are being planned to identify cases in which the member has a language preference other than English, then those cases can be examined to ensure that follow-up after hospitalization planning included the member's language needs. In the meantime, this will be included in the new monthly audit of discharges.

language other than English			
People (4) ***Member is not comfortable with telehealth***	**Ensure that discussion of telehealth barriers happens in the context of SDoH discussion during discharge planning**	New audit to start Q2 2022	A sample of discharge notes will be audited monthly by the QI team for inclusion of the consideration of SDoH in discharge planning, including barriers to the use of telehealth. Feedback will be provided to the Acute Inpatient Care Managers monthly.
Providers (1) ***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*** • ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process*** • ***Not involving the member's support***	**Partner with the Project RED researchers to provide education to providers, enhance use of Project-RED informed components, pilot fuller implementation of a version of RED modified for BH with select hospitals** **Continue to require "plan to obtain meds" as part of the discharge documentation.** **Ensure that any identified collaterals (natural or BH supports) are involved in discharge planning.** **Ensure that any current peer providers are alerted when a member is hospitalized.** **Continue to track and respond to ASC reports for "Inadequate Discharge Planning"**	Discussions began 2/2021 Include on new audit to start Q2 2022 Include on new audit to start Q2 2022 Examine process and identify barriers to implementing, Q2 2022	Meetings with Project RED researchers are tracked Training sessions by Project RED researchers will be tracked. Provider completion of a readiness assessment will be tracked. Other process measures will be determined later with the researchers. A sample of discharge notes will be audited monthly by the QI team for inclusion of the plan to obtain the discharge meds. This was previously audited as part of the discontinued monthly Project RED audits but included in new audits. A sample of discharge notes will be audited monthly by the QI team for inclusion of involved collaterals in discharge planning. Feedback will be given to the Acute Inpatient Care Managers monthly. Magellan Recovery & Resiliency Services team and System Transformation team will examine the current procedure for alerting case management providers about inpatient admissions and determine if there are any opportunities to include notifications to CPS/CRS providers when their assigned members are admitted to inpatient. If this becomes a

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
system in discharge/aftercare planning		7/2020 and ongoing	possibility, it will be monitored via routine claims reporting. If not a possibility, will strategize other ways this need might be met. Track monthly ASC data on inadequate discharge planning, and Provider intervention meetings related to discharge planning expectations.
Providers (2) ***"The Philadelphia Factor"*** • ***Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals***	**Invitation to Philadelphia based hospitals in the above collaborative effort with the Project RED researchers.** - **Continue to track and respond to ASC reports for "Inadequate Discharge Planning"**	Discussions began 2/2021 7/2020 and ongoing	Meetings with Project RED researchers are tracked Training sessions by Project RED researchers will be tracked. Provider completion of a readiness assessment will be tracked. Other process measures will be determined later with the researchers. Track monthly ASC data on inadequate discharge planning, specifically for Philadelphia hospitals, and Provider intervention meetings related to discharge planning expectations.
Providers (3) ***Outpatient provider availability*** • ***Lack of psychiatrist time overall*** • ***Providers not offering openings within seven days*** • ***Compounded by recent staffing shortages***	**Continue to track instances of "Access Barriers" in ASC system** **Rate increases to ensure competitive wages** **Lump sum staffing recruitment and retention payments to providers**	7/2020 and ongoing \ Began 2021, continue in 2022 2021	Track monthly ASC data on Access Barriers, and Provider intervention meetings related to discharge planning expectations. Tracked by Network and System Transformation teams (amounts, dates). Tracked by Network and System Transformation teams.
Policies / Procedures (1) ***Next steps needed for members at higher risk of not attending follow-up care***	**Health Guide- Community Transition Team—** Support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management. Locates community services for members, arranges access to follow-up care, and	Piloted in Cambria – Oct 2020 Other counties will fill positions -Q2 2022	Staff will keep a tracker of all members they support, and these will also include outcomes tracking of 7-day and 30-day FUH.

RCA for MY 2020 Underperformance: FUH 7–Day Measure (All Ages)			
	supports communication with hospitals and outpatient providers.		
Policies / Procedures (2) ***Open Access/Walk-In Intakes*** • ***Some outpatient providers will only offer open access which poses difficulty for members discharging from inpatient***	**Continue to track and respond to ASC reports of walk-in only being offered to members discharging from hospitals and other 24-hour care**	7/2020 and ongoing	Track monthly ASC data on walk-in FUH visits and related access barriers and intervention communication/meetings related to Magellan's expectations.
Policies / Procedures (3) ***Outpatient Provider Responsiveness*** • ***Lack of timely response to calls/ referrals from inpatient providers*** • ***Lack of timely response to calls from members*** • ***Lack of afternoon, evening and weekend appointments for intake***	**Front End Customer Service Assessments of OP Providers** **Track instances of "Access Barriers" in ASC system**	9/2020 and ongoing 7/2020 and ongoing	Calls will be made Q2 and Q3 of 2022, followed by an aggregate report and individualized reports to providers. Track monthly ASC data on access barriers and intervention communication/meetings related to Magellan's expectations.
Policies / Procedures (4) ***Quarantining policies & procedures*** • ***Inpatient providers- quarantining on AIP unit*** • ***Outpatient providers- when member tests***	**Ensure that members quarantined while in hospital received the same level of effective discharge planning.** **When members linked to Community Transition Team report that they have tested + for COVID, staff will assist in making alternate arrangements for FUH appointment.**	Q2 2022 Q2 2022	QI to have regular communication with Clinical team about the quarantine procedures of inpatient units and differences in services provided. Staff will keep a tracker of all members they support, and these will also include outcomes tracking of 7-day and 30-day FUH. Tracking will include barriers that arise to FUH appointments such as testing + for COVID.

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positive after discharge but before FUH visit			
Policies / Procedures (5) ***Provider challenges with claims resulting in claims denials***	**Network team promptly connecting with providers to resolve denied claims issues**	Monitoring by QI: Q1 2022	On a monthly basis the Network team reviews claim denial trends for each county. Any provider identified as having high denials receives an outreach to make sure they are aware and looks to correct the problems. Positive outcomes of this interventions are discussed in Network Strategy meetings monthly.
Provisions (1) *Lack of Transportation,* ***and Lack of knowledge of transportation resources***	**Handout on enrolling in MATP developed 6/2020 and also added to Magellan of PA website** **Ensure that discussion of transportation resources and barriers happens in all discharge planning.** **Provide a remote training for inpatient providers on how to access Medical Assistance Transportation Programs.**	6/2020 Q2 2022 To be scheduled	Continue to remind providers of MATP resources in all discharge discussions involving members identified as having no transportation resources. A sample of discharge notes will be audited monthly by the QI team for evidence of discussion of transportation resources/barriers in discharge planning. Feedback will be given to the Acute Inpatient Care Managers monthly. Will track which providers attend
Provisions (2) ***Member lack of technology to make use of telehealth***	**Include discussion of telehealth resources and barriers in discharge planning, when FUH appointment will be via telehealth.**	4/2021 and ongoing	A sample of discharge notes will be audited monthly by the QI team for evidence of discussion of member ability to use telehealth in discharge planning. Feedback will be given to the Acute Inpatient Care Managers monthly.

Table 6.3: MBH RCA and QIP for the 30-Day Measure (All Ages)

RCA for MY 2020 Underperformance: FUH 30-Day Measure (All Ages)	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): As in previous years, Magellan examined the 30-Day FUH data by first breaking it down by demographic factors to determine which factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, race, and ethnicity. The data in the State's Tableau database was examined via "head-to-head" comparisons between populations. Special attention was given to identifying disparities related to race, comparing FUH rates for the White subpopulation with the FUH rates for each non-White race group. Similarly, Magellan examined differences in FUH rates related to ethnicity via the head-to-head comparison for the Hispanic and non-Hispanic populations. Magellan also sought input on barriers to FUH by re-surveying inpatient providers with a survey similar to that which was administered last year, in order to identify any changes in barriers identified. This provider 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 2022"). Magellan decided to combine a few causal factors into "bundles" of causal factors, because the interventions planned would address the whole bundle and not just each single factor. 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. Extra attention centered on how to address identified disparities related to race and ethnicity. Please see the attachment "RCA 30-day FUH MY2020" for details and results of this analysis.	***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** Please refer to Magellan's root cause analysis, in this embedded document: Click here for the Ishikawa fishbone diagram of the root cause analysis conclusions: Below are several Logic Models of Change for Magellan's major interventions:
Quality Improvement Plan for CY 2022	
Rate Goal for 2022 (State the 2022 rate goal from your MY2020 FUH Goal Report here): **30-Day FUH Goal: 62.63%**	
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 2021 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the	

RCA for MY 2020 Underperformance: FUH 30-Day Measure (All Ages)			
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.*
People (1) ***Co-Occurring Disorders*** • ***Substance use relapse*** • ***SUD not sufficiently addressed***	**Magellan's Co-Occurring Competence Efforts—Internal Training/Coaching** **Incentivizing co-occurring competence among outpatient providers (Also a PIP intervention)**	2/2021 and ongoing 7/2021 and ongoing	Will monitor: --Frequency of trainings and mentoring sessions --Co-Occurring Disorder subject matter expert attends monthly Acute Inpatient Rounds, and has weekly "office hours" mentoring with Care Managers This effort is monitored via Magellan's Performance Improvement Project (PIP) effort and reported quarterly to OMHSAS and IPRO.
People (2) ***Member chooses to not pursue treatment*** • ***Past negative experiences with treatment*** • ***Believe they do not need treatment (at precontemplation stage)***	**Front End Customer Service Assessments of outpatient Providers** **Training for Providers on Precontemplation**	9/2020 and ongoing 4/28/2022	Calls will be made Q2 and Q3 of 2022, followed by an aggregate report and individualized reports to providers, with improvement recommendations. This is part of Magellan's Motivational Interviewing Training Series, mostly attended by SUD providers. Will track how many acute inpatient providers attend this session.
People (3) ***Member-specific demographic factors*** • ***Member-specific Social Determinants of***	**Include discussion of cultural factors in discharge planning** **Include discussion of SDoH factors that can impact FUH**	Q2 2022 3/2021 and ongoing.	A sample of discharge notes will be audited monthly by the QI team for inclusion of the consideration of cultural factors in discharge planning. Feedback will be provided to the Acute Inpatient Care Managers

RCA for MY 2020 Underperformance: FUH 30-Day Measure (All Ages)			
Health (SDoH) factors that present barriers to FUH • ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who are Black/ African American show lower FUH rates than members who identify as white).*** • ***Member speaks a language other than English***	**in all discharge planning discussions** **Ensure that when member prefers a language other than English that this is addressed in planning follow-up care**	New audit to start Q2 2022 New audit to start Q2 2022. New electronic health record anticipated to start Q3 2022.	monthly. A sample of discharge notes will be audited monthly by the QI team for inclusion of the consideration of SDoH in discharge planning. Feedback will be provided to the Acute Inpatient Care Managers monthly. Magellan's new clinical electronic health record is in the development stage, and reports are being planned to identify cases in which the member has a language preference other than English, then those cases can be examined to ensure that follow-up after hospitalization planning included the member's language needs. In the meantime, this will be included in the new monthly audit of discharges.
People (4) ***Member is not comfortable with telehealth***	**Ensure that discussion of telehealth barriers happens in the context of SDoH discussion during discharge planning**	New audit to start Q2 2022	A sample of discharge notes will be audited monthly by the QI team for inclusion of the consideration of SDoH in discharge planning, including barriers to the use of telehealth. Feedback will be provided to the Acute Inpatient Care Managers monthly.
Providers (1) ***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)***	**Partner with the Project RED researchers to provide education to providers, enhance use of Project-RED informed components, pilot fuller implementation of a version of RED modified for BH with select hospitals** **Continue to require "plan to obtain meds" as part of the discharge documentation.** **Ensure that any identified collaterals (natural or BH**	Discussions began 2/2021 Include on new audit to start Q2 2022	Meetings with Project RED researchers are tracked Training sessions by Project RED researchers will be tracked. Provider completion of a readiness assessment will be tracked. Other process measures will be determined later with the researchers.

RCA for MY 2020 Underperformance: FUH 30-Day Measure (All Ages)			
• ***No clear plan for obtaining medications*** • ***SDoH barriers not identified and addressed sufficiently in discharge planning process*** • ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process*** • ***Not involving the member's support system in discharge/aftercare planning***	**supports) are involved in discharge planning.** **Ensure that any current peer providers are alerted when a member is hospitalized.** **Continue to track and respond to ASC reports for "Inadequate Discharge Planning"**	Include on new audit to start Q2 2022 Examine process and identify barriers to implementing, Q2 2022 7/2020 and ongoing	A sample of discharge notes will be audited monthly by the QI team for inclusion of the plan to obtain the discharge meds. This was previously audited as part of the discontinued monthly Project RED audits but included in new audits. A sample of discharge notes will be audited monthly by the QI team for inclusion of involved collaterals in discharge planning. Feedback will be given to the Acute Inpatient Care Managers monthly. Magellan Recovery & Resiliency Services team and System Transformation team will examine the current procedure for alerting case management providers about inpatient admissions and determine if there are any opportunities to include notifications to CPS/CRS providers when their assigned members are admitted to inpatient. If this becomes a possibility, it will be monitored via routine claims reporting. If not a possibility, will strategize other ways this need might be met. Track monthly ASC data on inadequate discharge planning, and Provider intervention meetings related to discharge planning expectations.
Providers (2) ***"The Philadelphia Factor"***	**Invitation to Philadelphia- based hospitals in the above collaborative effort with the Project RED researchers.**	Discussions began 2/2021	Meetings with Project RED researchers are tracked

RCA for MY 2020 Underperformance: FUH 30-Day Measure (All Ages)			
• ***Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals***	**Continue to track and respond to ASC reports for "Inadequate Discharge Planning"**	7/2020 and ongoing	Training sessions by Project RED researchers will be tracked. Provider completion of a readiness assessment will be tracked. Other process measures will be determined later with the researchers. Track monthly ASC data on inadequate discharge planning, specifically for Philadelphia hospitals, and Provider intervention meetings related to discharge planning expectations.
Providers (3) ***Outpatient provider availability*** • ***Lack of psychiatrist time overall*** • ***Providers not offering openings within seven days*** • ***Compounded by recent staffing shortages***	**Continue to track instances of "Access Barriers" in ASC system** **Rate increases to ensure competitive wages** **Lump sum staffing recruitment and retention payments to providers**	7/2020 and ongoing Began 2021, continue in 2022 2021	Track monthly ASC data on Access Barriers, and Provider intervention meetings related to discharge planning expectations. Tracked by Network and System Transformation teams (amounts, dates). Tracked by Network and System Transformation teams.
Policies / Procedures (1) ***Next steps needed for members at higher risk of not attending follow-up care***	**Health Guide- Community Transition Team—** Support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management. Locates community services for members, arranges access to follow-up care, and supports communication with hospitals and outpatient providers.	Piloted in Cambria – Oct 2020 Other counties will fill positions -Q2 2022	Staff will keep a tracker of all members they support, and these will also include outcomes tracking of 7-day and 30-day FUH.
Policies / Procedures (2) ***Open Access/Walk-In Intakes*** • ***Some outpatient***	**Continue to track and respond to ASC reports of walk-in only being offered to members discharging from hospitals and other 24-hour care**	7/2020 and ongoing	Track monthly ASC data on walk-in FUH visits and related access barriers and intervention communication/meetings related to

RCA for MY 2020 Underperformance: FUH 30-Day Measure (All Ages)			
providers will only offer open access which poses difficulty for members discharging from inpatient			Magellan's expectations.
Policies / Procedures (3) ***Outpatient Provider Responsiveness*** • ***Lack of timely response to calls/ referrals from inpatient providers*** • ***Lack of timely response to calls from members*** • ***Lack of afternoon, evening and weekend appointments for intake***	**Front End Customer Service Assessments of OP Providers** **Track instances of "Access Barriers" in ASC system**	9/2020 and ongoing 7/2020 and ongoing	Calls will be made Q2 and Q3 of 2022, followed by an aggregate report and individualized reports to providers. Track monthly ASC data on access barriers and intervention communication/meetings related to Magellan's expectations.
Policies / Procedures (4) ***Quarantining policies & procedures*** • ***Inpatient providers- quarantining on AIP unit*** • ***Outpatient providers- when member tests positive after discharge but before FUH visit***	**Ensure that members quarantined while in hospital received the same level of effective discharge planning.** **When members linked to Community Transition Team report that they have tested + for COVID, staff will assist in making alternate arrangements for FUH appointment.**	Q2 2022 Q2 2022	QI to have regular communication with Clinical team about the quarantine procedures of inpatient units and differences in services provided. Staff will keep a tracker of all members they support, and these will also include outcomes tracking of 7-day and 30-day FUH. Tracking will include barriers that arise to FUH appointments such as testing + for COVID.

RCA for MY 2020 Underperformance: FUH 30-Day Measure (All Ages)			
Policies / Procedures (5) ***Provider challenges with claims resulting in claims denials***	**Network team promptly connecting with providers to resolve denied claims issues**	Monitoring by QI: Q1 2022	On a monthly basis the Network team reviews claim denial trends for each county. Any provider identified as having high denials receives an outreach to make sure they are aware and looks to correct the problems. Positive outcomes of this interventions are discussed in Network Strategy meetings monthly.
Provisions (1) *Lack of Transportation,* ***and Lack of knowledge of transportation resources***	**Handout on enrolling in MATP developed 6/2020 and also added to Magellan of PA website** **Ensure that discussion of transportation resources and barriers happens in all discharge planning.** **Provide a remote training for inpatient providers on how to access Medical Assistance Transportation Programs.**	6/2020 Q2 2022 To be scheduled	Continue to remind providers of MATP resources in all discharge discussions involving members identified as having no transportation resources. A sample of discharge notes will be audited monthly by the QI team for evidence of discussion of transportation resources/barriers in discharge planning. Feedback will be given to the Acute Inpatient Care Managers monthly. Will track which providers attend
Provisions (2) ***Member lack of technology to make use of telehealth***	**Include discussion of telehealth resources and barriers in discharge planning, when FUH appointment will be via telehealth.**	4/2021 and ongoing	A sample of discharge notes will be audited monthly by the QI team for evidence of discussion of member ability to use telehealth in discharge planning. Feedback will be given to the Acute Inpatient Care Managers monthly.

MBH: Magellan Behavioral Health; RCA: root cause analysis; CAP: corrective action plan; FUH: follow-up after hospital for mental illness; LGBTQIA: lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/ally.

VII: 2021 Strengths, Opportunities for Improvement and Recommendations

The section provides an overview of MBH's 2021 (MY 2020) performance in the following areas: structure and operations standards, PIPs, and PMs, with identified strengths and opportunities for improvement. This section also provides an assessment of the strengths and weaknesses of MBH with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (as described in 42 CFR 438.310(c)(2)).

Strengths

- MBH successfully submitted a PIP proposal for the PEDTAR topic.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2018, RY 2019, and RY 2020 found MBH to be partially compliant with three sections associated with MMC regulations.
  - MBH was partially compliant with 2 out of 9 categories within Compliance with Standards, including Enrollee Rights and Protections. The partially compliant categories are Assurances of Adequate Capacity and Services and Availability of Services.
  - MBH was partially compliant with the eponymous category in Quality Assessment and Performance Improvement Program.
  - MBH was partially compliant with the single category of Grievance and Appeal Systems within Grievance System.
- MBH's MY 2020 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- and 30-day Follow-Up After Hospitalization for Mental Illness MY 2020 rates (QI 1 and QI2) were, for all age sets except the 7-day rate for ages 18-64, statistically significantly worse than the previous year.
- MBH's PA-specific 7- and 30-day Follow-Up After Hospitalization for Mental Illness MY 2020 rates (QI A and QI B) for the all ages age set were statistically significantly worse than the previous year.
- MBH's MY 2020 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.
- Review of compliance with standards conducted by the Commonwealth in RY 2018, RY 2019, and RY 2020 found MBH to be partially compliant with Network Adequacy.

Assessment of Quality, Timeliness, and Access

Responsibility for quality, timeliness, and access to health care services and supports is distributed among providers, payers, and oversight entities. Due to the BH carve-out within Pennsylvania's HealthChoices program, BH-MCOs and PH-MCOs operate under separate contracts, with BH-MCOs contracting with non-overlapping Primary Contractors, making this distribution even more complex. That said, when it comes to improving healthcare quality, timeliness, and access, the BH-MCO can focus on factors closer to its locus of control.

Table 7.1 details the full list of recommendations that are made for the MCO for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for the year. The PIP recommendations may include issues from prior years if they remain unresolved. Since 2020 was the baseline year, and the MCO met all requirements of the proposal stage, there are no recommendations applicable for this review period. For performance measures, the strengths and opportunities noted above in this section are determined for the current year, while recommendations are based on issues that were not only identified as opportunities for the current 2021 (MY 2020) year but were also identified as outstanding opportunities from 2020 (MY 2019).

Table 7.1: EQR Recommendations

Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	No recommendations	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide- Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management."	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide- Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management."	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	MBH should continue to conduct root cause analyses into the drivers of readmissions among members discharged from an inpatient psychiatric stay. It should leverage the barrier analyses already conducted for its PEDTAR PIP. MBH identified significant opportunities for improvement in several areas, starting with high rates of AMA and AWOL discharges from high levels of SUD inpatient care. The PIP interventions as a set seek to address the entire continuum of care, including prevention and early detection as well a complex chronic disease management of comorbid conditions. MBH's multifaceted approach targeting both member engagement but also provider training and network enhancements places the MCO in a strong position to improve quality, timeliness, and access to care for its members.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Coverage and authorization of services	MBH was partially compliant with a substandard related to the correct use of available denial letter templates. MBH should ensure that it consistently uses the correct applicable template, including the Additional Information Template when needed.	Timeliness, Access
Quality assessment and performance improvement program	MBH was noncompliant with one substandard requiring regular reporting to the Department of Human Services (DHS) on accurate and timely QM data. IPRO concurs with the corrective action plan: The MBH Program Description, Work Plan and Program Evaluation should identify specific due dates for submission to remain consistent with the External Quality Review (EQR) PEPS Matrix that is distributed by OMHSAS annually to the Primary Contractors and BH-MCOs.	Quality, Timeliness, Access
Grievance and appeal systems	MBH was partially compliant with Grievance and appeal systems standard due to deficiencies associated with maintaining effective oversight of the complaint process. IPRO concurs with the findings of the corrective action plan: Decision letters need to be clear and concise by including a summary of the findings from the investigation rather than explaining the entire	Quality, Timeliness, Access

	investigation process. IPRO concurs with the following recommendations: Magellan should develop criteria to determine when an on-site provider review is warranted (e.g., health and safety concerns). It also recommended that Magellan outline criteria to determine when follow-up is needed, and Magellan should develop a process to determine member satisfaction with the Complaint outcome and document where appropriate. MBH was also partially compliant with substandards concerned with the communication of Grievance and Fair Hearing processes, procedures and Member rights. MBH should formalize a process to follow up with members to assess satisfaction with the Grievance process. In addition, MBH should identify criteria related to onsite provider reviews and follow-up actions.	

EQR: external quality review; MCO: managed care organization; N/A: not applicable.

VIII: Summary of Activities

Performance Improvement Projects

- MBH submitted a new PIP proposal on the PEDTAR topic for 2020.

Performance Measures

- MBH reported all performance measures and applicable quality indicators for 2020.

Structure and Operations Standards

- MBH was partially compliant with Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement Program, and Grievance System. As applicable, compliance review findings from RY 2020, RY 2019, and RY 2018 were used to make the determinations.

Quality Studies

- DHS and OMHSAS launched ICWC in 2020. For any of its members receiving ICWC services, MBH covered those services under a Prospective Payment System rate.

2020 Opportunities for Improvement MCO Response

- MBH provided a response to the opportunities for improvement issued in 2021.

2021 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for MBH in 2021 (MY 2020). The BH-MCO will be required to prepare a response in 2022 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.[25]

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

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

BBA Category	PEPS Reference	PEPS Language
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Substandard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Confidentiality 42 C.F.R. § 438.224	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Coordination and continuity of care 42 C.F.R. § 438.208	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights

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

BBA Category	PEPS Reference	PEPS Language
42 C.F.R. § 438.330		treatment, such as Behavioral Health Rehabilitation Services Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs.
	Substandard 91.4	The QM Work Plan includes: Objective Aspect of care/service Scope of activity Frequency Data source Sample size Responsible person Specific, measurable, attainable, realistic and timely performance goals, as applicable.
	Substandard 91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	Substandard 91.6	The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.
	Substandard 91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	Substandard 91.8	The QM Work Plan includes a provider profiling process.
	Substandard 91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: Telephone access and responsiveness rates Overall utilization patterns and trends including BHRS and other high volume/high risk services.
	Substandard 91.10	The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.
	Substandard 91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Substandard 91.12	The QM Work Plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Evaluation
	Substandard 91.13	The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year
	Substandard 91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.
	Substandard 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

BBA Category	PEPS Reference	PEPS Language
		the work plan.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
	Substandard 98.1	The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate
	Substandard 98.2	The BH-MCO reports monitoring results for overall utilization patterns and trends, including BHRS service utilization and other high volume/high risk services patterns of over- or under-utilization. BH-MCO takes action to correct utilization problems, including patterns of over- and under-utilization.
	Substandard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Substandard 104.1	The BH-MCO must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
Grievance and appeal systems 42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	Substandard 68.1	Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint procedures are made known to Members, BH-MCO staff and the provider network. • 1st level • 2nd level • External • Expedited • Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	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

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

[25] In 2019, 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.

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-specific PEPS substandards.[26]

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 68.8	Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role.
Grievances	Substandard 71.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 71.1.2	Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.
	Substandard 71.5	A verbatim transcript and/or recording of the Grievance review meeting is 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 71.6	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.

Category	PEPS Reference	PEPS Language
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements.
Executive Management		
County Executive Management	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/Family Satisfaction	Substandard 108.3	County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program.
	Substandard 108.4	The C/FST Director is responsible for: setting program direction consistent with County direction; negotiating contract; prioritizing budget expenditures; recommending survey content and priority; and directing staff to perform high quality surveys.
	Substandard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling, and have resulted in provider action to address issues identified.

[26] In 2019, 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.

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 RY 2020, 18 OMHSAS-specific substandards were evaluated for MBH and its Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in RY 2020, 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 2020	RY 2019	RY 2018
Care Management					
Care Management (CM) Staffing	1	0	0	1	0
Longitudinal Care Management (and Care Management Record Review)	1	0	0	1	0
Complaints and Grievances					
Complaints	5	0	0	5	0
Grievances	5	0	0	5	0
Denials					
Denials	1	0	1	0	0
Executive Management					
County Executive Management	1	0	0	1	0
BH-MCO Executive Management	1	0	0	1	0
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	3	0	0
Total	**18**	**0**	**4**	**14**	**0**

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

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Substandard 27.7	2019	All MBH Primary Contractors	-	-
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	2019	All MBH Primary Contractors	-	-

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

Complaints and Grievances

The OMHSAS-specific PEPS substandards relating to second-level complaints and grievances include MCO-specific and County-specific review standards. MBH and its Primary Contractors were evaluated on 10 of the 10 applicable substandards. Of the 10 substandards evaluated, MBH partially met 4 substandards, as indicated in **Table C.3.**

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Complaints and Grievances					
Complaints	Substandard 68.1.1	2019	Delaware, Lehigh, Montgomery, Northampton	Bucks, Cambria	-
	Substandard 68.1.2	2019	Bucks, Cambria, Lehigh, Montgomery, Northampton	Delaware	-
	Substandard 68.5	2019	All MBH Primary Contractors	-	-
	Substandard 68.6	2019	All MBH Primary Contractors	-	-
	Substandard 68.8	2019	All MBH Primary Contractors	-	-
Grievances	Substandard 71.1.1	2019	Bucks, Delaware, Lehigh, Montgomery, Northampton	Cambria	-
	Substandard 71.1.2	2019	Bucks, Lehigh, Montgomery, Northampton	Cambria, Delaware	-
	Substandard 71.5	2019	All MBH Primary Contractors	-	-
	Substandard 71.6	2019	All MBH Primary Contractors	-	-
	Substandard 71.8	2019	All MBH Primary Contractors	-	-

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

MBH was partially compliant with Substandards 1 and 2 within PEPS Standard 68.1 (RY 2019).

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

Substandard 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.

MBH was partially compliant with Substandards 1 and 2 within Standard 71.1 (RY 2019).

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, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

Substandard 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.

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 and its Primary Contractors were evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Denials					
Denials	Substandard 72.3	2020	All MBH Primary Contractors	-	-

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

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 and its Primary Contractors Cambria, Lehigh, and Northampton were evaluated for the County Executive Management and were found fully compliant. MBH and all its Primary Contractors were evaluated on the BH-MCO Executive Management substandard and were compliant. The status for these substandards is presented in **Table C.5**.

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

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Executive Management					
County Executive Management	Substandard 78.5	2019	Cambria, Lehigh, Northampton	-	-
BH-MCO Executive Management	Substandard 86.3	2019	All MBH Primary Contractors	-	-

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; MBH: Magellan Behavioral Health; BH-MCO: Behavioral Health Managed Care Organization.

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 Primary Contractor		
			Met	Partially Met	Not Met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Substandard 108.3	2020	All MBH Primary Contractors	-	-
	Substandard 108.4	2020	All MBH Primary Contractors	-	-
	Substandard 108.9	2020	All MBH Primary Contractors	-	-

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