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# Magellan Behavioral Health

## External Quality Review

## Annual Technical Report

**April 2024**

**Review Period: January 1, 2023–December 31, 2023**

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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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 Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2023 EQRs for HealthChoices (HC) behavioral health MCOs (BH-MCOs) and to prepare the annual 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

The HC BH Program is the mandatory managed care program that provides Medical Assistance recipients with BH services in PA. The PA DHS OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with PA for the administration of the HC BH Program. In such cases, DHS 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 BH-MCO to manage the HC BH Program. Effective January 1, 2022, all 67 counties exercised their right of first opportunity to contract, either alone or in combination with other counties, with a BH-MCO.

In the interest of operational efficiency, numerous counties have come together to create HC oversight entities (HC-OEs) that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases, the HC-OE is the Primary Contractor, and in other cases, multiple Primary Contractors contract with an HC-OE to manage their HC BH Program. In the MBH managed care network, Bucks, Cambria, Lehigh, Montgomery, and Northampton counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors. On July 1, 2022, Delaware County changed its contract from MBH to Community Care Behavioral Health (CCBH). Medicaid managed care (MMC) compliance findings for any HC-OE changing MCO contracts are not included in BBA reporting for a period of three years after the change.

## Objectives

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

- validation of performance improvement projects (PIPs),
- validation of MCO performance measures (PMs),
- review to determine plan compliance with structure and operations standards established by the state (*Title 42 Code of Federal Regulations [CFR] Section [§] 438.358*), and
- validation of MCO network adequacy.

### Scope of EQR Activities

In accordance with the updates to the Centers for Medicare & Medicaid Services (CMS) EQRO Protocols released in February 2023,[2] this technical report includes eight core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Compliance with Medicaid Managed Care Regulations
IV. Validation of Network Adequacy
V. Quality Studies
VI. MCO Responses to 2022 EQR Recommendations
VII. 2023 Strengths, Opportunities for Improvement, and Recommendations
VIII. Summary of Activities

For the MCO, information for **Sections I** and **II** is derived from IPRO's validation of the MCO's PIPs and PM submissions. The PM validation, as conducted by IPRO, included a repeated measurement of three PMs: Healthcare Effectiveness Data and Information Set (HEDIS®) Follow-Up After Hospitalization for Mental Illness, PA-specific Follow-Up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. Until 2023, information for compliance with MMC regulations in **Section III** was derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity, when applicable, against PA's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI). Beginning in 2023, the PEPS standards and compliance data were migrated to the Systematic Monitoring, Access, and Retrieval Technology (SMART) application. **Section IV** discusses the validation of MCO network adequacy in relation to existing federal and state standards. **Section V** discusses the quality study for the Integrated Community Wellness Centers (ICWC) program. **Section VI** includes the MCO's responses to opportunities for improvement noted in the 2022 (measurement year [MY] 2021) EQR annual 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 2022), as determined by IPRO, as well as a "report card" of the MCO's performance as related to the quality indicators 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. Also included are the following: **References** with a list of publications cited and **Appendices** that include crosswalks of SMART standards to pertinent BBA regulations and to OMHSAS-specific SMART substandards, as well as results of the SMART review for OMHSAS-specific standards.

# 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 PIP for the MCO. 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.

The name of the current PIP project is "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders (SUD)." The Aim Statement for this PIP reads: "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."

The PIP has three common clinical objectives (for all MCOs) and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an opioid use disorder (OUD) and/or other SUD.
2. Improve retention in treatment for members with an OUD and/or other SUD diagnosis.
3. Increase concurrent use of drug and alcohol counseling in conjunction with pharmacotherapy (medication-assisted treatment [MAT]).
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 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 is a HEDIS measure that 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 (AOD) dependence primary diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. This measures discharges, not individuals (starting from Day 1 of the MY; if there are multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended 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 mental health conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for mental health conditions before they reach a critical stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary mental health diagnosis 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 OUD in the measurement period who received both BH counseling services and 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 ages 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 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 ages 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 2024, including a one-year extension, with initial PIP proposals submitted in 2020 and a final report due in September 2025. 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 related 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 meetings with each MCO. The purpose of these meetings 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[Error! Bookmark not defined.] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project, as they are reported using an annual form, for compliance with the following eight review elements:

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. The evaluation consists of the review findings being considered to determine whether the PIP results should be accepted as valid and reliable. In accordance with the EQR PIP validation protocol issued by CMS in February 2023, BH replaced the former scoring with two qualitative assessments of the PIP, expressed in terms of levels of confidence (High, Moderate, and Low or None): 1) EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases; and 2) EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement.

The results for demonstrable and sustainable improvement will be reported by the MCO and evaluated by the EQRO at the end of the current PIP cycle and reported in a subsequent EQR annual technical report.

## Findings

MBH 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 calendar year (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, applying motivational interviewing training, and expanding 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.

On the whole, MBH's Year 2 report was a thoroughly written account of all aspects of the PIP. There was solid documentation of findings from intervention tracking measures (ITMs) to analyses (e.g., trending of AWOL/AMA discharge rates, trending of discharge plan audit results, disparities, etc.), including ancillary data and building to conclusions that are well supported. IPRO did, however, note the need for a performance indicator to specifically measure progress on its population prevention objectives. Only occasionally does discussion miss the mark, as, for example, the discussion around potential impacts of Delaware's exit on certified recovery specialist (CRS) utilization among Hispanic members (it has more to do with Delaware's contributions to both the denominator and numerator). Data and discussion were often nuanced (e.g., exploration of the differences between case managers and providers addressing relapse prevention in discharge planning, the application of the Motivational Interviewing framework to understanding provider change, etc.), making for a rich discussion.

### Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases

Based on review of MBH's Year 2 report, there is moderate confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results. As relates to Rating 1, IPRO recommends the following:

- MBH should implement at least one performance indicator of its general population (community prevention) objectives. The relative participation of CRS services among African American and Hispanic members could serve this role for Objective 6; however, the Objective 5 related to prevention and early detection would seem to suggest the need for another measure. One possibility is for MBH to run an administrative measure of screening, brief intervention, and referral to treatment (SBIRT) or similar screening encounters, albeit one limited to its own enrolled members. This carries the advantage of being able to retroactively calculate a 2020 baseline. Another possibility is an education and outreach campaign with community-based providers and recovery supports to address the lingering stigma attached to pharmacotherapy as, for example, among certain Alcoholics Anonymous (AA) groups, which would help address a barrier to improving MAT rates. Such a measure could be operationalized in the form of a survey or questionnaire.
- Overall, the report has become too large, and IPRO encourages MBH to pare down the content, perhaps by removing historical passages that are less germane to a current reporting year. Leaving aside the lack of a formalized population strategy performance indicator and the report length, however, MBH's report can serve as a model for other MCO reports.

### Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement

There is moderate confidence that the PIP produced evidence of significant improvement. SAR rates showed improvement over Year 1, while MHR rates did not (after improving over baseline). All other performance indicator rates (FUI, MAT-AUD, and MAT-OUD) worsened since Year 1. As relates to Rating 2, IPRO recommends the following:

- MBH makes a strong case for expecting improvement down the line based on steady improvements in many of its ITMs, which serve as useful leading indicators. Actualization of those improvements, however, will depend on continued effort, vigilance, and a readiness to adjust if needed.

# II: Validation of Performance Measures

## Objectives

In MY 2022, OMHSAS's HC Quality Program required MCOs to run three PMs as part of their Quality Assessment and Performance Improvement (QAPI) Program: HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), PA-specific FUH, and Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA). Studies were remeasured in 2022. IPRO validated all three PMs reported by each MCO for MY 2022 to ensure that the PMs were implemented to specifications and state reporting requirements (*Title 42 CFR § 438.330[b][2]*).

### Follow-Up After Hospitalization for Mental Illness

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. 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.

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).

There were four separate measurements related to the FUH measure. All utilized the same denominator but had different numerators.

#### *Eligible Population for HEDIS Follow-Up*

The entire eligible population was used for all 24 Primary Contractors participating for MY 2022. 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, 2022;
- a principal International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code indicating one of the specified mental health disorders;
- 6 years of age and older 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, 2022, 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, 2022. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2022 methodology for the FUH 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 24 Primary Contractors participating for MY 2022. 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 or intentional self-harm occurring between January 1 and December 2, 2022;
- 6 years of age and older 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, 2022, 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, 2022. The PA-specific measure has been adjusted to allow discharges up through December 2, 2022, 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**
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 standards 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**
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 standards 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*

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.[5] Avoidable inpatient readmission is 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 SUD.[6] 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 2022 results will be examined in the context of the 2019 novel coronavirus (COVID-19) pandemic, which has been implicated in the rising prevalence of mental illness.[7] 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 the FUH measure, OMHSAS elected to retain and remeasure the REA indicator for this year's EQR. This study examined BH 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 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 24 Primary Contractors participating for MY 2022. 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 2, 2022;
- a principal 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.

## Technical Methods of Data Collection and Analysis

The source for all information was administrative data provided to IPRO by the BH-MCOs. The source for all administrative data was the BH-MCOs' transactional claims systems. 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 to resubmit, as necessary.

### Performance Goals

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. Similarly, REA rates that are greater than the state's goal of 11.75% result in an RCA and QIP assignment. For this measure, lower rates indicate better performance. This process is further discussed in **Section VI**.

### 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 2021 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *Z*-test 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:

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

Where:

*N*1 = current year numerator,
*N*2 = prior year numerator,
*D*1 = current year denominator, and
*D*2 = prior year denominator.

The single proportion estimate was then used for estimating the standard error (SE). The *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 quality indicator rate, and
*p*2 = prior year 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) and 95% confidence intervals (CIs) for the difference between the two proportions were also calculated. CIs were not calculated if denominators of rates contained fewer than 100 members.

### Limitations

The tables and figures in this section present rates, CIs, and tests of statistical significance for Primary Contractors. Due to differences in 7-day versus 30-day quality indicators, scales in figures may vary. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from *Z*-tests of the PM results. In addition, this 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 18–64 years, ages 6+ years, and ages 6–17 years. The 6+ years ("All Ages") age group results are presented to show the follow-up rates for the overall HEDIS population, and the 6–17 years 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 only.

The results are presented at the BH-MCO and Primary Contractor levels. The BH-MCO-specific rates were calculated using the numerator and denominator 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% 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 and the 18–64 years age groups are compared to the HEDIS 2023 (MY 2022) 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 6–17 years age group are not compared to HEDIS benchmarks.

## I: HEDIS Follow-Up Indicators

**a) Age Group: Ages 18–64 Years**

**Table 2.1** shows the MY 2022 results for both the HEDIS 7-day and 30-day follow-up measures for members ages 18–64 years compared to MY 2021.

Table 2.1: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Indicators (Ages 18–64 Years)

| Measure[1] | MY 2022 (N) | MY 2022 (D) | MY 2022 % | MY 2022 95% CI Lower | MY 2022 95% CI Upper | MY 2021 % | MY 2022 Rate Comparison to MY 2021 PPD | MY 2022 Rate Comparison to MY 2021 SSD | MY 2022 Rate Comparison to MY 2022 HEDIS Medicaid Percentiles |
|---|---|---|---|---|---|---|---|---|---|
| QI 1 – HEDIS 7-Day Follow-Up (Ages 18–64 Years) | | | | | | | | | |
| Statewide | 8965 | 27548 | **32.5%** | 32.0% | 33.1% | 34.3% | -1.7 | Yes | Below 75th percentile, above 50th percentile |
| MBH | 1559 | 4513 | **34.5%** | 33.1% | 35.9% | 34.1% | 0.4 | No | Below 75th percentile, above 50th percentile |
| Bucks | 277 | 827 | **33.5%** | 30.2% | 36.8% | 35.6% | -2.1 | No | Below 75th percentile, above 50th percentile |
| Cambria | 182 | 403 | **45.2%** | 40.2% | 50.1% | 36.4% | 8.8 | Yes | At or above 75th percentile |
| Delaware | 102 | 421 | **24.2%** | 20.0% | 28.4% | 32.0% | -7.8 | Yes | Below 25th percentile |
| Lehigh | 379 | 1064 | **35.6%** | 32.7% | 38.5% | 33.3% | 2.4 | No | Below 75th percentile, above 50th percentile |
| Montgomery | 408 | 1148 | **35.5%** | 32.7% | 38.4% | 37.1% | -1.5 | No | Below 75th percentile, above 50th percentile |
| Northampton | 211 | 650 | **32.5%** | 28.8% | 36.1% | 29.5% | 2.9 | No | Below 75th percentile, above 50th percentile |
| QI 2 – HEDIS 30-Day Follow-Up (Ages 18–64 Years) | | | | | | | | | |
| Statewide | 14322 | 27548 | **52.0%** | 51.4% | 52.6% | 53.7% | -1.7 | Yes | Below 50th percentile, above 25th percentile |
| Magellan | 2324 | 4513 | **51.5%** | 50.0% | 53.0% | 54.2% | -2.7 | Yes | Below 50th percentile, above 25th percentile |
| Bucks | 438 | 827 | **53.0%** | 49.5% | 56.4% | 56.3% | -3.3 | No | Below 50th percentile, above 25th percentile |
| Cambria | 237 | 403 | **58.8%** | 53.9% | 63.7% | 59.0% | -0.2 | No | Below 75th percentile, above 50th percentile |
| Delaware | 166 | 421 | **39.4%** | 34.6% | 44.2% | 47.1% | -7.6 | Yes | Below 25th percentile |
| Lehigh | 574 | 1064 | **53.9%** | 50.9% | 57.0% | 53.6% | 0.4 | No | Below 75th percentile, above 50th percentile |
| Montgomery | 570 | 1148 | **49.7%** | 46.7% | 52.6% | 57.9% | -8.2 | Yes | Below 50th percentile, above 25th percentile |
| Northampton | 339 | 650 | **52.2%** | 48.2% | 56.1% | 52.8% | -0.6 | No | Below 50th percentile, above 25th percentile |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; QI: quality indicator; MBH: Magellan Behavioral Health.

**Figure 2.1** is a graphical representation of MY 2022 HEDIS FUH 7-day and 30-day follow-up rates in the ages 18–64 years population for MBH and its associated Primary Contractors. The orange line represents the MCO average.

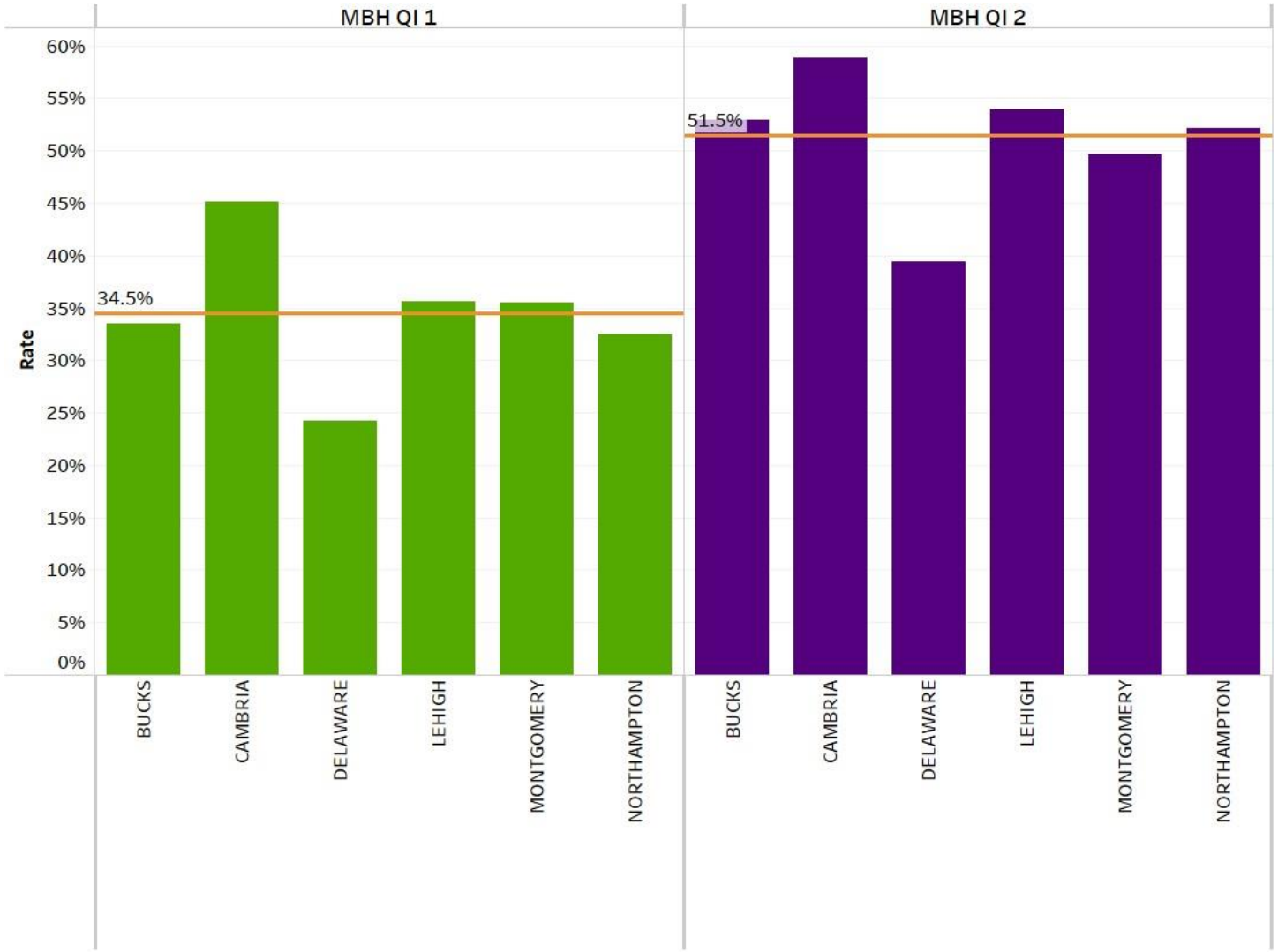


Figure 2.1: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Rates (Ages 18–64 Years)

**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 statewide rate.

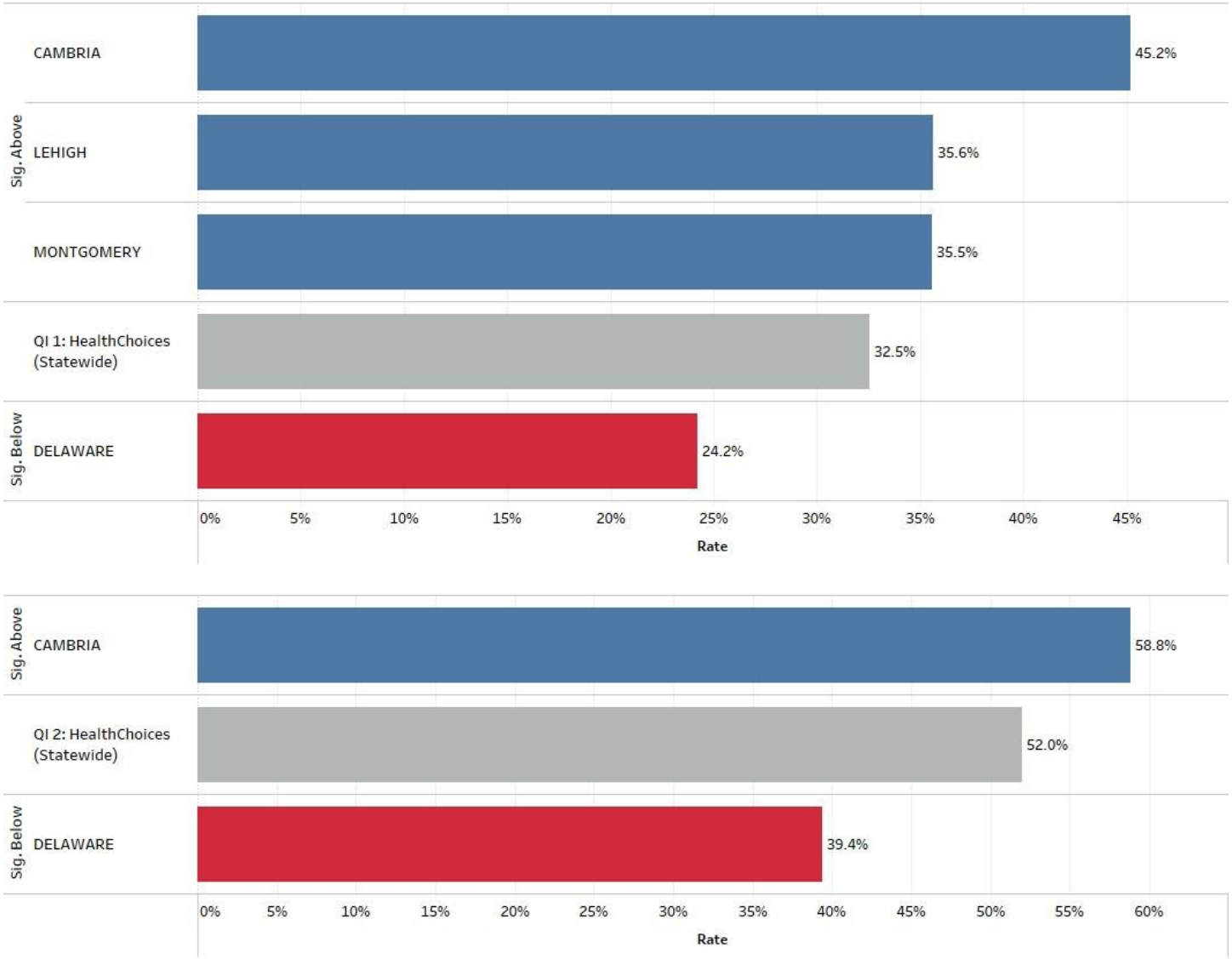


Figure 2.2: SSDs in MBH Contractor MY 2022 HEDIS FUH Rates (Ages 18–64 Years) MBH Primary Contractor MY 2022 HEDIS FUH rates for 18–64 years of age that are statistically significantly different than statewide rates.

**b) Overall Population: Ages 6+ Years**

**Table 2.2** shows the MY 2022 aggregate results for both the HEDIS 7-day and 30-day follow-up measures compared to MY 2021.

Table 2.2: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Indicators (All Ages)

| Measure[1] | MY 2022 (N) | MY 2022 (D) | MY 2022 % | MY 2022 95% CI Lower | MY 2022 95% CI Upper | MY 2021 % | MY 2022 Rate Comparison to MY 2021 PPD | MY 2022 Rate Comparison to MY 2021 SSD | MY 2022 Rate Comparison to MY 2022 HEDIS Medicaid Percentiles |
|---|---|---|---|---|---|---|---|---|---|
| QI 1 – HEDIS 7-Day Follow-Up (All Ages) | | | | | | | | | |
| Statewide | 13025 | 35443 | **36.7%** | 36.2% | 37.3% | 37.7% | -1.0 | Yes | Below 75th percentile, above 50th percentile |
| MBH | 2245 | 5849 | **38.4%** | 37.1% | 39.6% | 35.6% | 2.8 | Yes | Below 75th percentile, above 50th percentile |
| Bucks | 401 | 1057 | **37.9%** | 35.0% | 40.9% | 38.7% | -0.7 | No | Below 50th percentile, above 25th percentile |
| Cambria | 251 | 537 | **46.7%** | 42.4% | 51.1% | 34.2% | 12.5 | Yes | At or above 75th percentile |
| Delaware | 142 | 524 | **27.1%** | 23.2% | 31.0% | 33.3% | -6.2 | Yes | Below 25th percentile |
| Lehigh | 526 | 1342 | **39.2%** | 36.5% | 41.8% | 34.7% | 4.5 | Yes | Below 75th percentile, above 50th percentile |
| Montgomery | 620 | 1514 | **41.0%** | 38.4% | 43.5% | 38.4% | 2.5 | No | Below 75th percentile, above 50th percentile |
| Northampton | 305 | 875 | **34.9%** | 31.6% | 38.1% | 31.9% | 3.0 | No | Below 50th percentile, above 25th percentile |
| QI 2 – HEDIS 30-Day Follow-Up (All Ages) | | | | | | | | | |
| Statewide | 20002 | 35443 | **56.4%** | 55.9% | 57.0% | 57.9% | -1.4 | Yes | Below 50th percentile, above 25th percentile |
| MBH | 3243 | 5849 | **55.4%** | 54.2% | 56.7% | 57.1% | -1.7 | No | Below 50th percentile, above 25th percentile |
| Bucks | 603 | 1057 | **57.0%** | 54.0% | 60.1% | 60.2% | -3.2 | No | Below 50th percentile, above 25th percentile |
| Cambria | 340 | 537 | **63.3%** | 59.1% | 67.5% | 59.8% | 3.5 | No | Below 75th percentile, above 50th percentile |
| Delaware | 223 | 524 | **42.6%** | 38.2% | 46.9% | 50.4% | -7.9 | Yes | Below 25th percentile |
| Lehigh | 776 | 1342 | **57.8%** | 55.1% | 60.5% | 56.0% | 1.9 | No | Below 50th percentile, above 25th percentile |
| Montgomery | 829 | 1514 | **54.8%** | 52.2% | 57.3% | 60.2% | -5.5 | Yes | Below 50th percentile, above 25th percentile |
| Northampton | 472 | 875 | **53.9%** | 50.6% | 57.3% | 56.8% | -2.8 | No | Below 50th percentile, above 25th percentile |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; QI: quality indicator; MBH: Magellan Behavioral Health.

**Figure 2.3** is a graphical representation of the MY 2022 HEDIS FUH follow-up rates for MBH and its associated Primary Contractors. The orange line represents the MCO average.

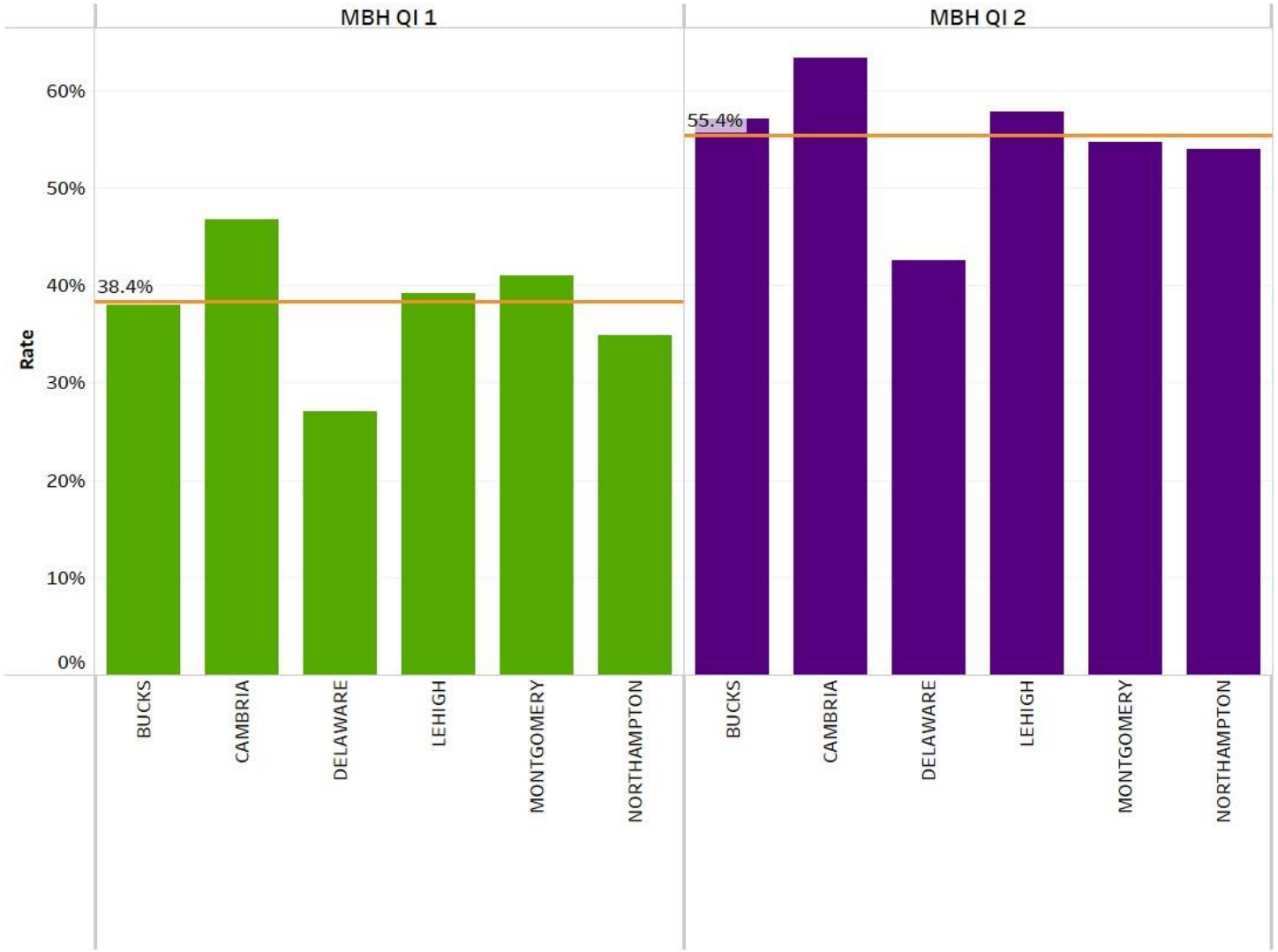


Figure 2.3: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Rates (All Ages)

**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 the statewide rate.

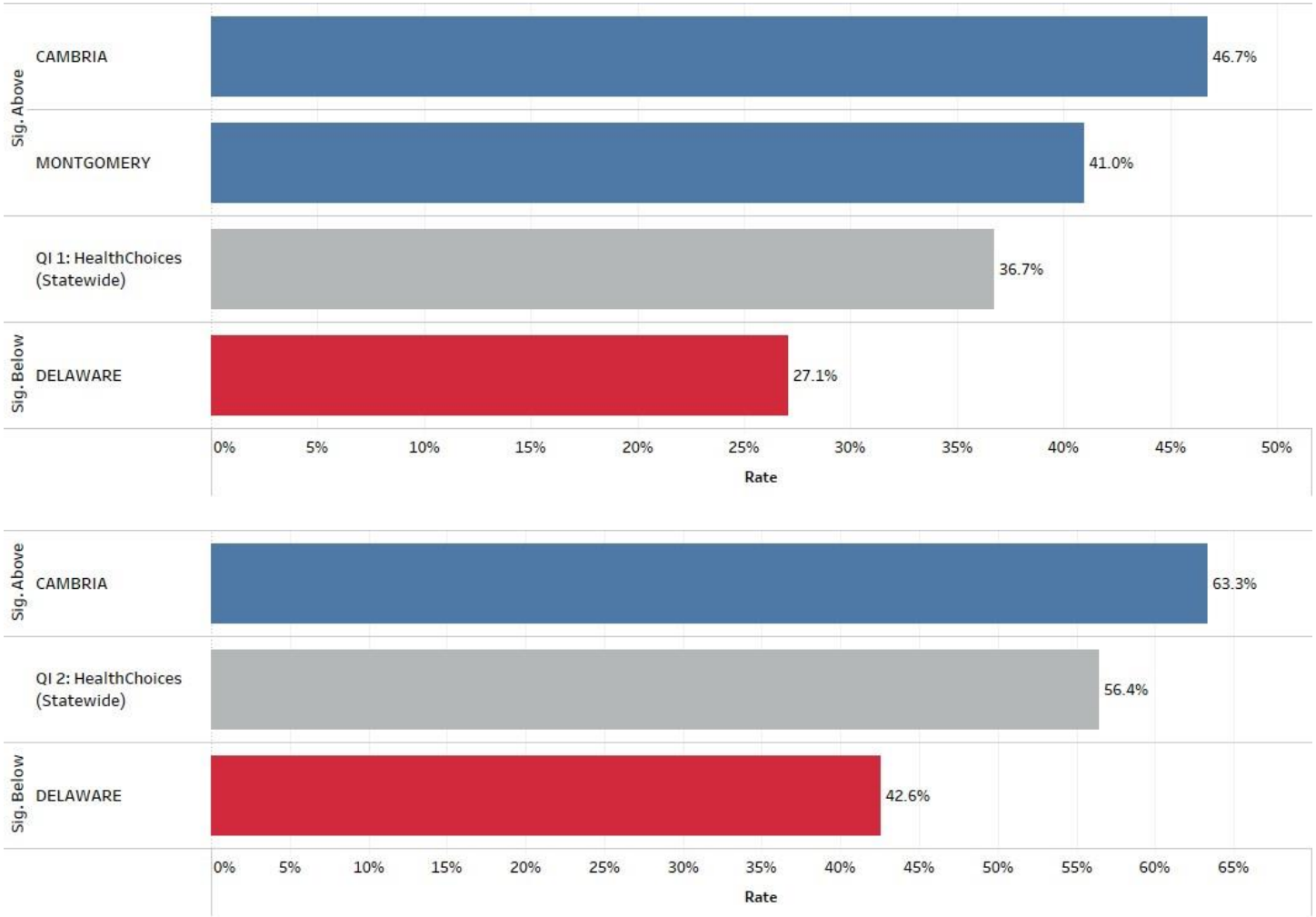


Figure 2.4: SSDs in MBH Contractor MY 2022 HEDIS FUH Rates (All Ages) MBH Primary Contractor MY 2022 HEDIS FUH rates for all ages that are statistically significantly different than statewide rates.

**c) Age Group: Ages 6–17 Years**

**Table 2.3** shows the MY 2022 results for both the HEDIS FUH 7-day and 30-day follow-up measures for members ages 6–17 years compared to MY 2021.

Table 2.3: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Indicators (Ages 6–17 Years)

| Measure[1] | MY 2022 (N) | MY 2022 (D) | MY 2022 % | MY 2022 95% CI Lower | MY 2022 95% CI Upper | MY 2021 % | MY 2022 Rate Comparison to MY 2021 PPD | MY 2022 Rate Comparison to MY 2021 SSD |
|---|---|---|---|---|---|---|---|---|
| QI 1 − HEDIS 7-Day Follow-Up (Ages 6−17 Years) | | | | | | | | |
| Statewide | 3881 | 7144 | **54.3%** | 53.2% | 55.5% | 52.3% | 2.0 | Yes |
| MBH | 654 | 1199 | **54.5%** | 51.7% | 57.4% | 42.0% | 12.6 | Yes |
| Bucks | 120 | 205 | **58.5%** | 51.5% | 65.5% | 50.0% | 8.5 | No |
| Cambria | 67 | 125 | **53.6%** | 44.5% | 62.7% | 26.8% | 26.8 | Yes |
| Delaware | 40 | 97 | **41.2%** | N/A | N/A | 40.5% | 0.7 | N/A |
| Lehigh | 134 | 249 | **53.8%** | 47.4% | 60.2% | 40.2% | 13.7 | Yes |
| Montgomery | 201 | 315 | **63.8%** | 58.3% | 69.3% | 45.5% | 18.3 | Yes |
| Northampton | 92 | 208 | **44.2%** | 37.2% | 51.2% | 39.5% | 4.7 | No |
| QI 2 − HEDIS 30-Day Follow-Up (Ages 6−17 Years) | | | | | | | | |
| Statewide | 5406 | 7144 | **75.7%** | 74.7% | 76.7% | 75.9% | -0.2 | No |
| MBH | 878 | 1199 | **73.2%** | 70.7% | 75.8% | 69.9% | 3.4 | No |
| Bucks | 158 | 205 | **77.1%** | 71.1% | 83.1% | 75.6% | 1.4 | No |
| Cambria | 100 | 125 | **80.0%** | 72.6% | 87.4% | 63.4% | 16.6 | Yes |
| Delaware | 56 | 97 | **57.7%** | N/A | N/A | 68.7% | -11.0 | N/A |
| Lehigh | 186 | 249 | **74.7%** | 69.1% | 80.3% | 65.6% | 9.1 | Yes |
| Montgomery | 247 | 315 | **78.4%** | 73.7% | 83.1% | 71.6% | 6.8 | No |
| Northampton | 131 | 208 | **63.0%** | 56.2% | 69.8% | 70.5% | -7.5 | No |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference; QI: quality indicator; MBH: Magellan Behavioral Health; N/A: not applicable, confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

**Figure 2.5** is a graphical representation of the MY 2022 HEDIS FUH 7-day and 30-Day follow-up rates in the ages 6–17 years population for MBH and its associated Primary Contractors. The orange line represents the MCO average.

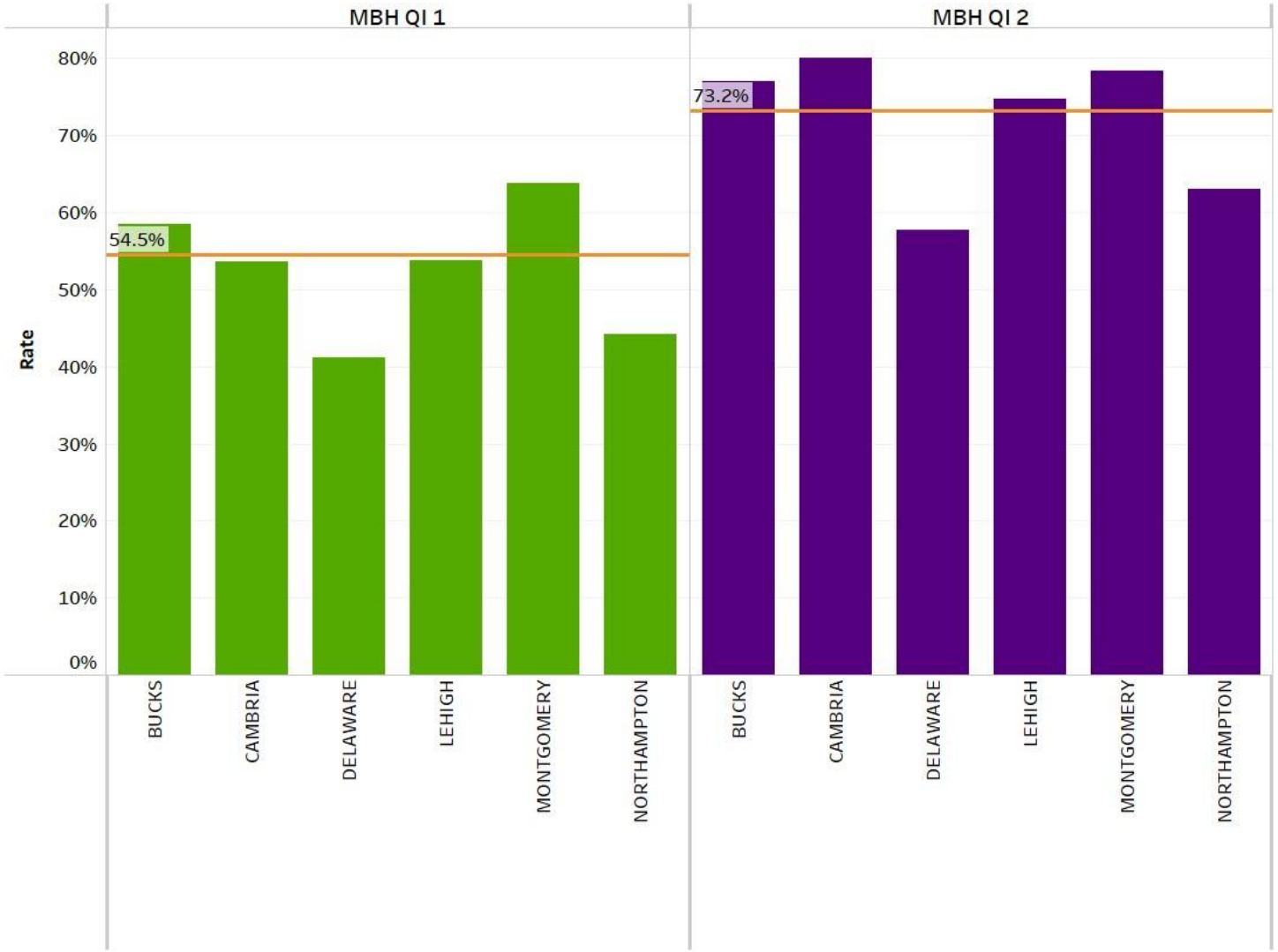


Figure 2.5: MY 2022 HEDIS FUH 7-Day and 30-Day Follow-Up Rates (Ages 6–17 Years)

**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 rate.

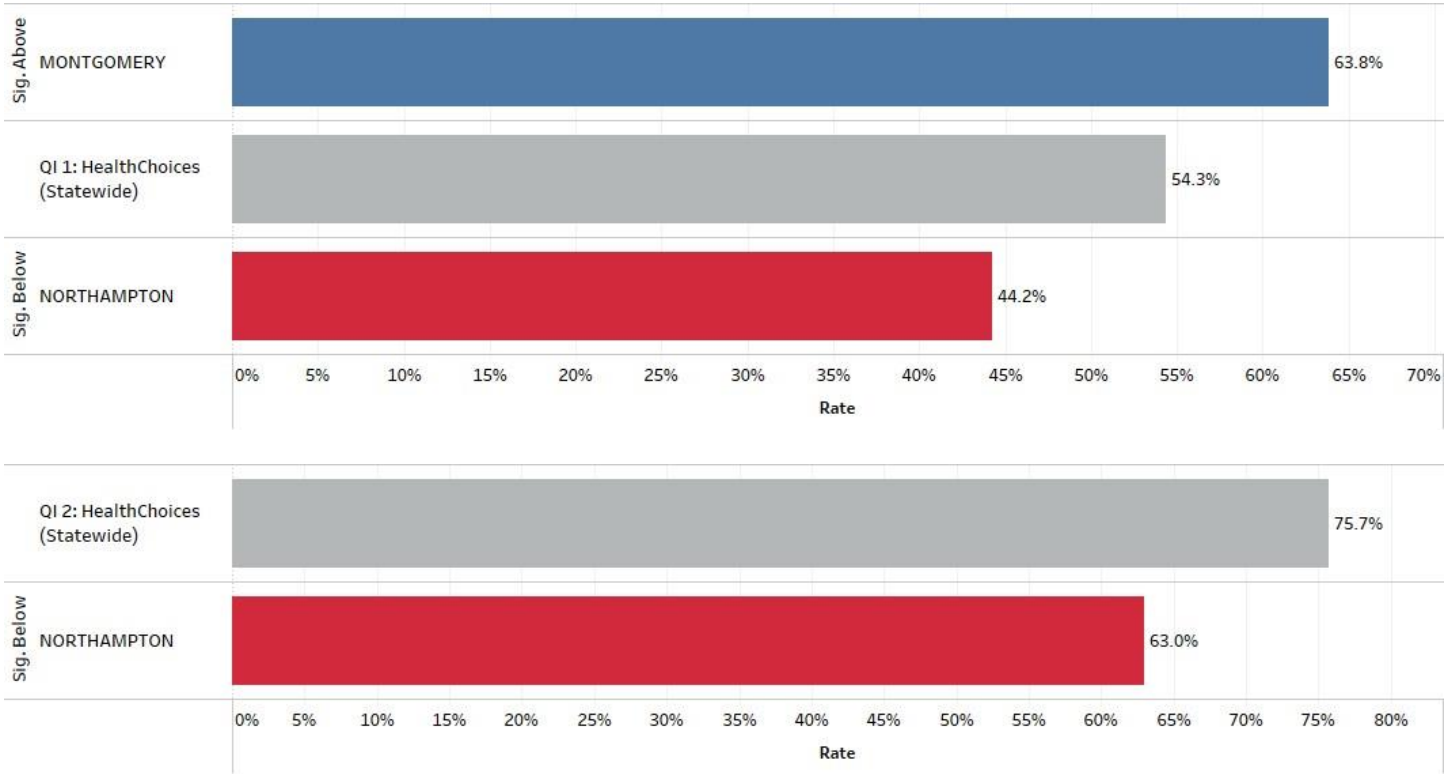


Figure 2.6: SSDs in MBH Contractor MY 2022 HEDIS FUH Rates (Ages 6–17 Years) MBH Primary Contractor MY 2022 HEDIS FUH rates for 6–17 years of age that are statistically significantly different than statewide rates.

## II: PA-Specific Follow-Up Indicators

**a) Overall Population: Ages 6+ Years**

**Table 2.4** shows the MY 2022 PA-specific FUH 7-day and 30-day follow-up indicators for all ages compared to MY 2021.

Table 2.4: MY 2022 PA-Specific FUH 7-Day and 30-Day Follow-Up Indicators (All Ages)

| Measure[1] | MY 2022 (N) | MY 2022 (D) | MY 2022 % | MY 2022 95% CI Lower | MY 2022 95% CI Upper | MY 2021 % | MY 2022 Rate Comparison to MY 2021 PPD | MY 2022 Rate Comparison to MY 2021 SSD |
|---|---|---|---|---|---|---|---|---|
| QI A – PA-Specific 7-Day Follow-Up (All Ages) | | | | | | | | |
| Statewide | 15210 | 34916 | **43.6%** | 43.0% | 44.1% | 48.8% | -5.3 | Yes |
| MBH | 2573 | 5747 | **44.8%** | 43.5% | 46.1% | 46.2% | -1.4 | No |
| Bucks | 455 | 1032 | **44.1%** | 41.0% | 47.2% | 49.1% | -5.0 | Yes |
| Cambria | 278 | 520 | **53.5%** | 49.1% | 57.8% | 49.2% | 4.2 | No |
| Delaware | 177 | 524 | **33.8%** | 29.6% | 37.9% | 41.0% | -7.2 | Yes |
| Lehigh | 587 | 1331 | **44.1%** | 41.4% | 46.8% | 44.8% | -0.7 | No |
| Montgomery | 714 | 1483 | **48.1%** | 45.6% | 50.7% | 51.0% | -2.9 | No |
| Northampton | 362 | 857 | **42.2%** | 38.9% | 45.6% | 41.0% | 1.3 | No |
| QI B – PA-Specific 30-Day Follow-Up (All Ages) | | | | | | | | |
| Statewide | 21363 | 34916 | **61.2%** | 60.7% | 61.7% | 65.9% | -4.7 | Yes |
| MBH | 3498 | 5747 | **60.9%** | 59.6% | 62.1% | 62.0% | -1.2 | No |
| Bucks | 634 | 1032 | **61.4%** | 58.4% | 64.5% | 63.9% | -2.5 | No |
| Cambria | 366 | 520 | **70.4%** | 66.4% | 74.4% | 66.9% | 3.5 | No |
| Delaware | 250 | 524 | **47.7%** | 43.3% | 52.1% | 54.7% | -7.0 | Yes |
| Lehigh | 823 | 1331 | **61.8%** | 59.2% | 64.5% | 61.6% | 0.2 | No |
| Montgomery | 916 | 1483 | **61.8%** | 59.3% | 64.3% | 64.9% | -3.1 | No |
| Northampton | 509 | 857 | **59.4%** | 56.0% | 62.7% | 62.1% | -2.7 | No |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 rates.

MY: measurement year; FUH: Follow-Up After Hospitalization for Mental Illness; CI: confidence interval; N: numerator; D: denominator; PPD: percentage-point difference; SSD: statistically significant difference QI: quality indicator; MBH: Magellan Behavioral Health.

**Figure 2.7** is a graphical representation of the MY 2022 PA-specific follow-up rates for MBH and its associated Primary Contractors. The orange line represents the MCO average.

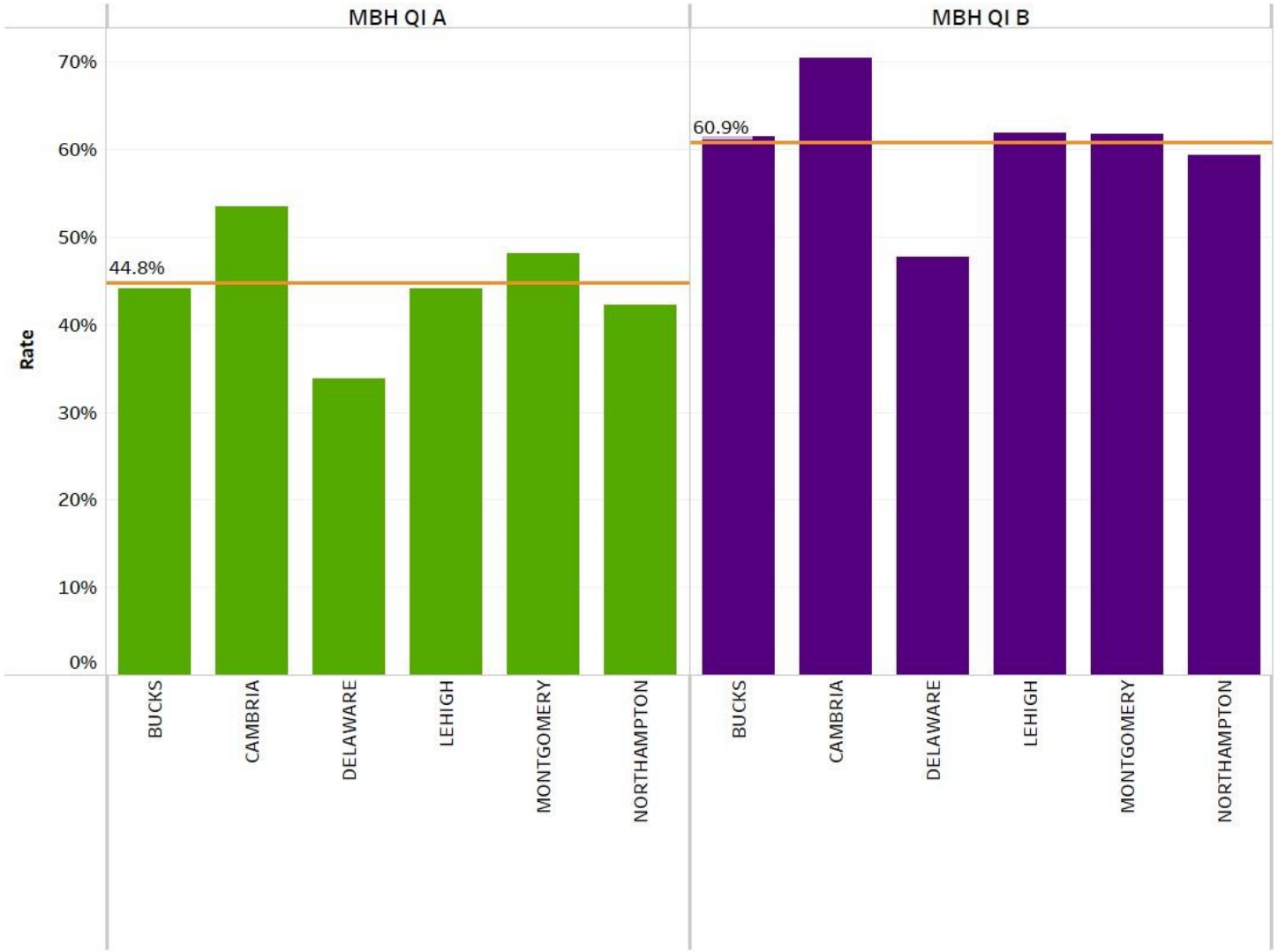


Figure 2.7: MY 2022 PA-Specific FUH 7-Day and 30-Day Follow-Up Rates (All Ages)

**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 rate.

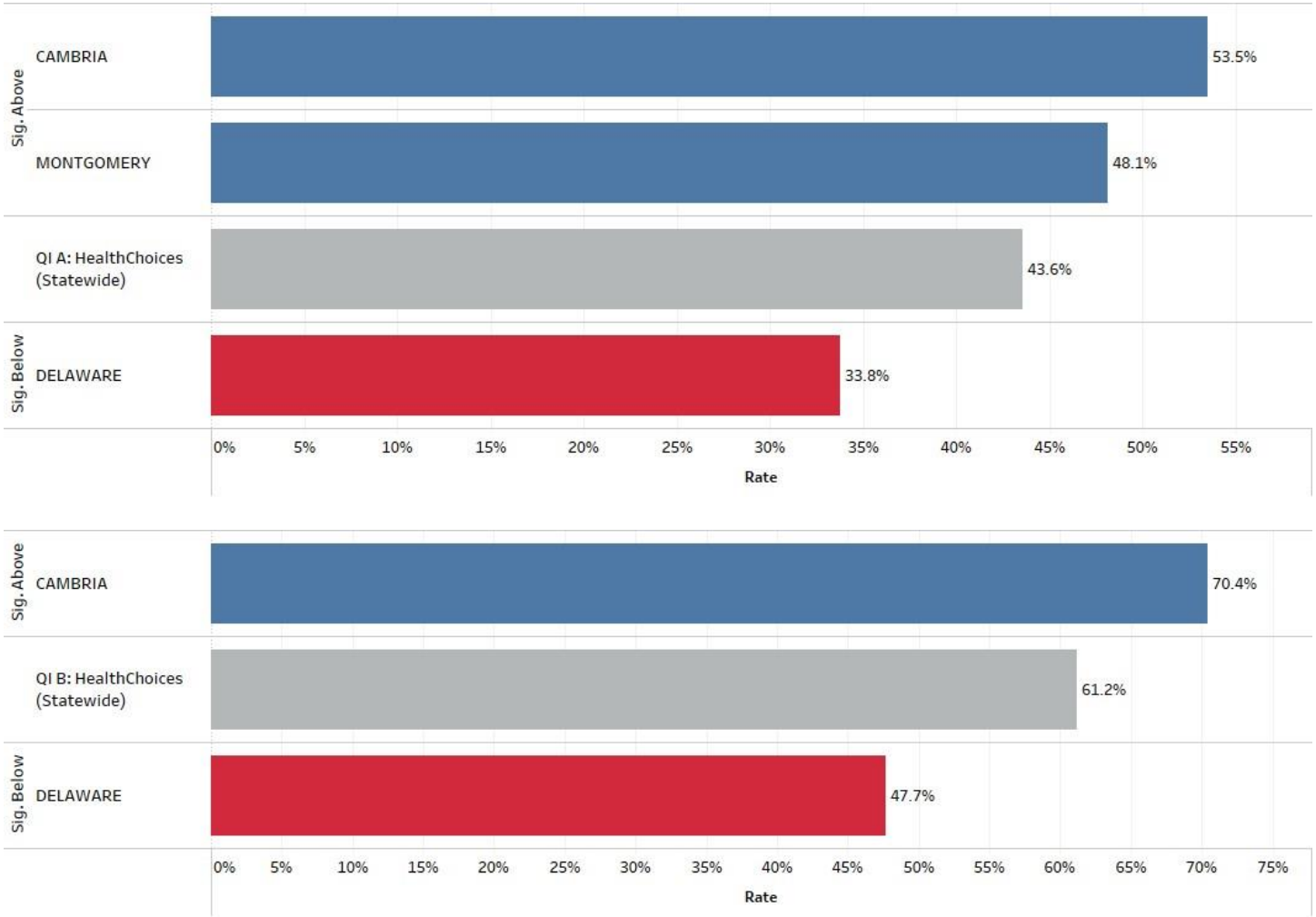


Figure 2.8: SSDs in MBH Contractor MY 2022 PA-Specific FUH Rates (All Ages) MBH Primary Contractor MY 2022 PA-specific FUH rates for all ages that are statistically significantly different than statewide rates.

## III: Readmission Indicators

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2022 to MY 2021 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories. 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 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 11.75%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 11.75% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2022 REA Readmission Indicators (All Ages)

| Measure[1,2] | MY 2022 (N) | MY 2022 (D) | MY 2022 % | MY 2022 95% CI Lower | MY 2022 95% CI Upper | MY 2021 % | MY 2022 Rate Comparison to MY 2021 PPD | MY 2022 Rate Comparison to MY 2021 SSD |
|---|---|---|---|---|---|---|---|---|
| Inpatient Readmission | | | | | | | | |
| Statewide | 5821 | 44420 | **13.1%** | 12.8% | 13.4% | 13.2% | -0.1 | No |
| MBH | 933 | 7266 | **12.8%** | 12.1% | 13.6% | 14.0% | -1.1 | Yes |
| Bucks | 141 | 1317 | **10.7%** | 9.0% | 12.4% | 13.2% | -2.5 | No |
| Cambria | 77 | 627 | **12.3%** | 9.6% | 14.9% | 8.7% | 3.6 | Yes |
| Delaware | 108 | 713 | **15.1%** | 12.4% | 17.8% | 14.3% | 0.8 | No |
| Lehigh | 268 | 1717 | **15.6%** | 13.9% | 17.4% | 16.6% | -1.0 | No |
| Montgomery | 232 | 1869 | **12.4%** | 10.9% | 13.9% | 13.2% | -0.8 | No |
| Northampton | 107 | 1023 | **10.5%** | 8.5% | 12.4% | 14.5% | -4.0 | Yes |

[1] The OMHSAS-designated PM goal is a readmission rate at or below 11.75%.

[2] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2022 and MY 2021 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; MBH: Magellan Behavioral Health.

**Figure 2.9** is a graphical representation of the MY 2022 readmission rates for MBH and its associated Primary Contractors. The orange line represents the MCO average.

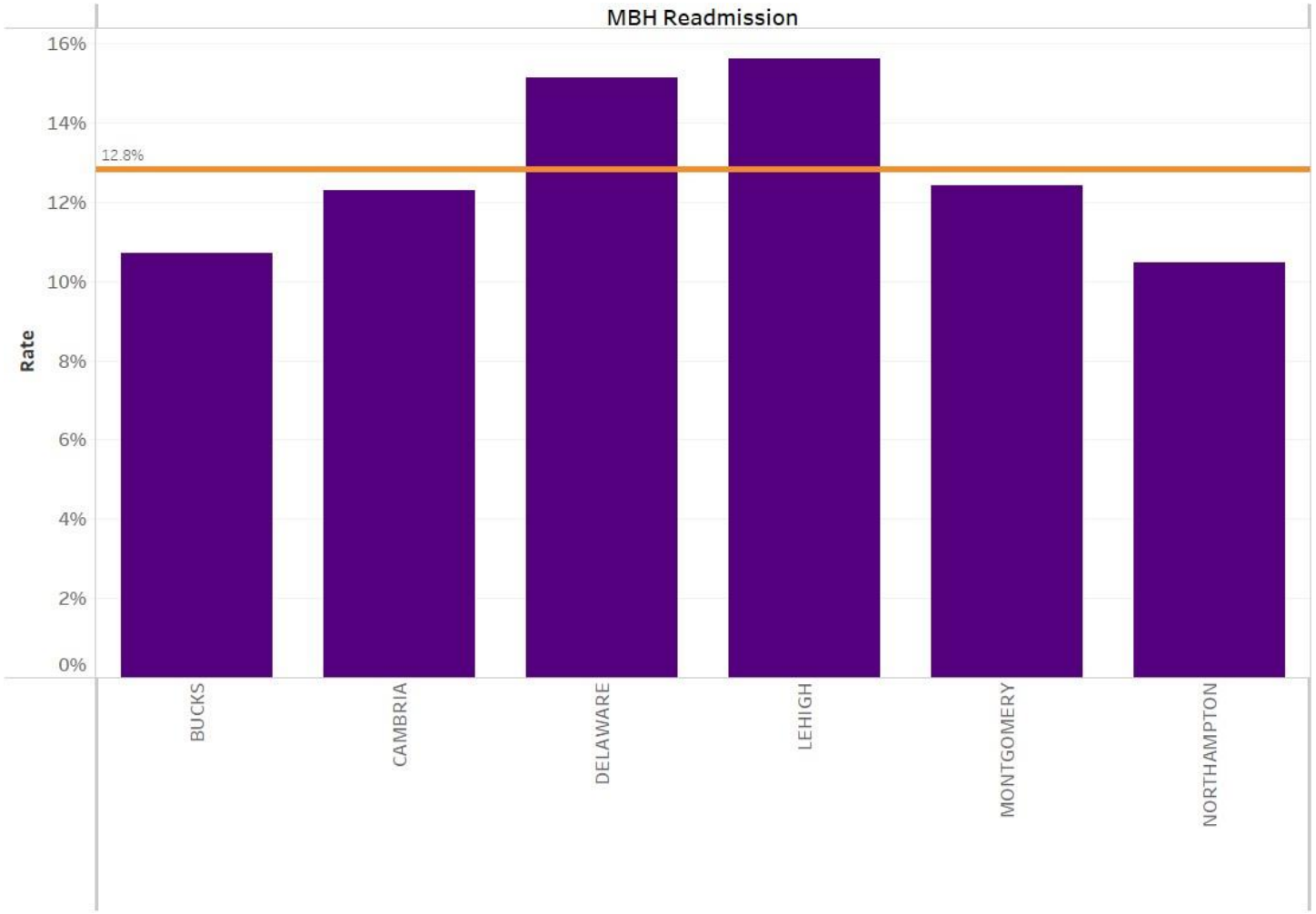


Figure 2.9: MY 2022 REA Rates for MBH Primary Contractors (All Ages)

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

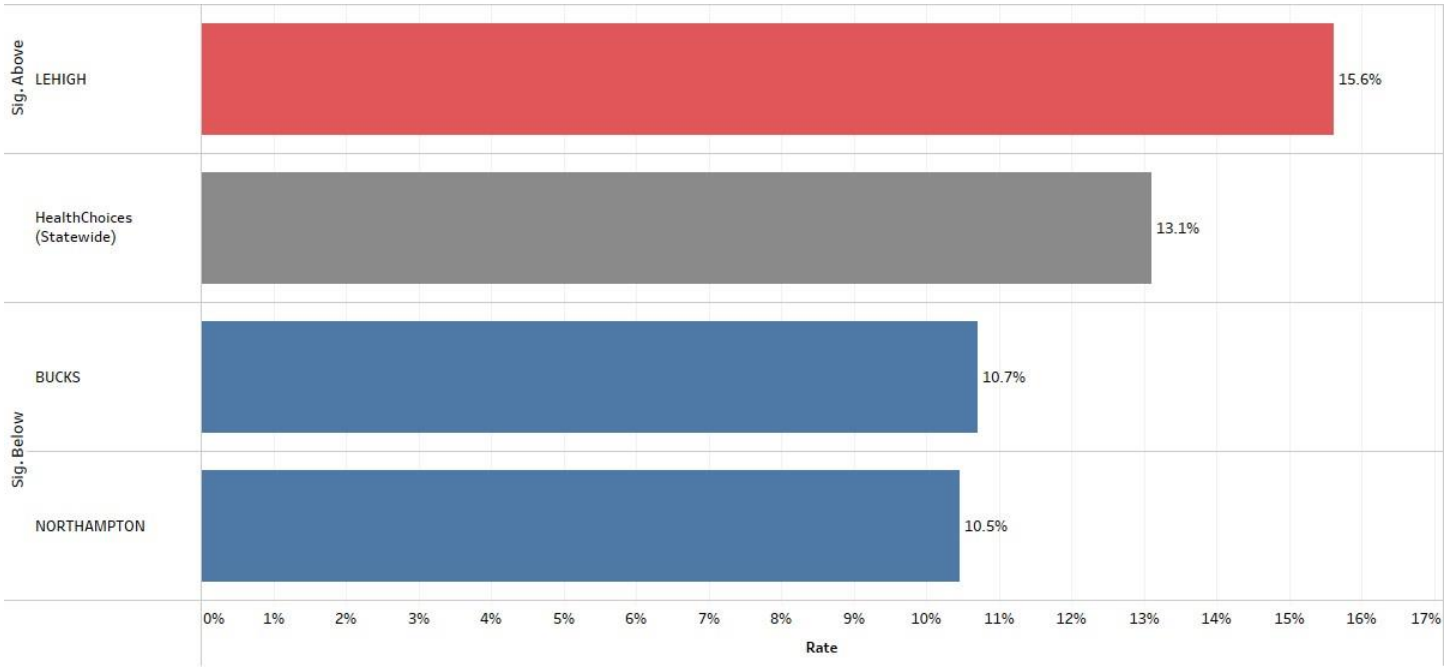


Figure 2.10: SSDs in MBH Primary Contractor MY 2022 REA Rates (All Ages) MBH Primary Contractor MY 2022 REA rates for all ages that are statistically significantly different than statewide rates.

## Recommendations

Overall, MY 2022 saw mixed results for MBH and its Primary Contractors with respect to FUH rates. MBH's HEDIS FUH all ages 7-day rate increased, led by Cambria County, and the improvement was statistically significant, while the HEDIS FUH 30-day rate significantly improved for the ages 18−64 years group. The most striking improvement, however, was in the ages 6−17 years group, which saw a 12.6 percentage point jump, led by Cambria, Lehigh, and Montgomery counties. Still, MBH's HEDIS FUH all ages rates were below the HEDIS Quality Compass 75th percentiles. In contrast, MBH's REA rates improved, led by Bucks and Northampton counties, and the decrease in rates was statistically significant. MBH fell just short (above) the statewide goal of 11.75%.

Efforts should continue to be made to improve FUH performance, particularly for those BH-MCOs that performed below the HC BH statewide rate. The following are recommendations that are informed by the MY 2022 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 2013 and 2022, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. MBH's comprehensive RCAs and QIPs for its HEDIS 7-day and 30-day FUH rates demonstrates that the MCO and its Primary Contractors have a solid grasp of the multidimensional drivers of their FUH rates, including staff shortages, especially at inpatient facilities that impede communications and workflows (especially related to discharge planning); network adequacy for certain provider types that may lead to longer wait times or difficulty finding therapeutically aligned providers; social determinants of health (SDoH) barriers to making and keeping follow-up appointments; complex medical and BH needs of members; lack of provider understanding of how to best facilitate step-down care; and technical barriers to telehealth uptake. IPRO concurs with MBH's proposed remediations outlined in its QIPs, which, taken together, provide a multipronged response. These include innovative value-based payment (VBP) arrangements ranging in scope from inpatient facilities to peer and recovery support providers, automation of care management workflows with trigger points for SDoH-positive screens or other adverse results, expansion of Project RED, internal and external audits ranging from record reviews to reviews of trauma-informed care, and enhanced telehealth supports.
- It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. 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 2023 (MY 2022) 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 subpopulations and their outcomes as measured by performance measures like FUH. The IPRO Tableau® report is one source BH-MCOs can use to investigate potential health disparities in FUH. To this end, MBH and its Primary Contractors reported that the Hispanic population had higher FUH rates than the non-Hispanic population, while no racial disparities between White members and non-White members were detected in MY 2022. Related to the ethnic disparity finding, IPRO recommends MBH incorporate consideration of any disparities into their RCAs and QIPs, even if disparities appear to favor non-majority groups, as the goal ultimately is to eliminate health care disparities in general. One way to do this is to consider including other variables in statistical models, such as urban versus rural residence. This may in turn reveal deeper causes that suggest effective responses.

Continued efforts should be made to improve performance with regard to REA, particularly for those BH-MCOs and Primary Contractors that did not meet the performance goal and/or performed below the HC BH statewide rate. In response to the 2022 study, the following are recommendations for improving (reducing) readmission rates after psychiatric discharge:

- 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 2020, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A PIP starting in 2021 builds on the previous PIP by, among other things, including a performance indicator that measures mental health-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. MBH's RCA and QIP for its REA, which fell just short of the statewide goal, addresses many of the factors identified for low FUH rates while also addressing factors specific to

readmissions. For example, in results seen elsewhere, MBH identified a relatively small cohort of members contributing a large share of the psychiatric readmissions. MBH notes that this group may respond well to peer support and/or enhanced case management services, provided they are successfully engaged. MBH's ongoing and planned interventions overlap with those concerned with FUH while also addressing readmission-specific issues, such as cultural education and training for member-facing staff and eventually providers. MBH should continue to engage with its logic models of change to ensure that data are being collected at appropriate frequencies along all the important points of the chains of causation so that hypotheses about what is or is not working can be made and tested. Insights from those analyses can then be used to inform recalibrations of interventions or, if necessary, of the logic models themselves.

- 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 2023 (MY 2022) REA Rates Report produced by the EQRO, which is being made available to BH MCOs in an interactive Tableau workbook. For MY 2022, MBH found that African American/Black members were less likely to obtain follow-up care, as measured by FUH, compared to White members, and this disparity appeared to be most pronounced in males. MBH speculates this may be related to cultural factors such as stigma, as well as a lack of practitioners in the network who are African American/Black, compounded by poor prior experiences with the health care system in general. MBH did not find any ethnic health disparities in MY 2022 REA rates.

# 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) 2022, 67 PA counties participated in this compliance evaluation.

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

Bucks, Cambria, Lehigh, Montgomery, and Northampton counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors. On July 1, 2022, Delaware changed its contract from MBH to CCBH. MMC compliance findings for any HC-OE changing MCO contracts are not included in BBA reporting for a period of three years after the change. **Table 3.1** shows the name of the HC-OE, the associated HC Primary Contractor(s), and the county/counties 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 |
| 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 three RYs (RYs 2022, 2021, and 2020). These evaluations are performed at the BH-MCO and Primary Contractor levels, and the findings are reported in the SMART application for 2022. 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 three-year timeframe under consideration, the RAI was provided to IPRO. For those Primary Contractors and BH-MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review substandards were deemed as complete. As necessary, the HC BH PS&R 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 late 2022 and entered into the SMART application as of early 2023. Information captured within the SMART application informs this report. The SMART application contains a comprehensive set of monitoring standards that OMHSAS staff review on an ongoing basis for each BH-MCO. Within each standard, the SMART 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 to collect or capture additional reviewer comments. Based on the SMART application, a BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against related supplemental OMHSAS-specific SMART substandards that are part of OMHSAS's more rigorous monitoring criteria.

The standards that are subject to EQR review are contained in *Title 42 CFR Part 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. 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 or changes to state

standards. As changes are made to EQR reporting requirements, IPRO works with PA OMHSAS to update its crosswalk to the PS&R Agreement, SMART data, Information Systems Capability Assessments (ISCAs), external audit findings, and any other relevant data that pertain to federal provisions or state standards. Standards or substandards that are introduced or retired are done so following the rotating three-year schedule for all five BH-MCOs. This may, in turn, change the category tally of standards from one reporting year to the next. A null value is indicated where no crosswalk was available for a given provision for the RY period or no data for the applicable RY period were available for the reviewed managed care plan (MCP). The CMS EQRO protocols released in 2023[Error! Bookmark not defined.] included modifications to the BBA provisions that are now required for reporting. These updates to reporting include the addition of three new federal standards (Disenrollment, Enrollee Rights, and Emergency and Post-Stabilization Services) with results becoming available for MCPs following the aforementioned three-year schedule.

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 2022 crosswalks of substandards to pertinent BBA regulations and to pertinent OMHSAS-specific substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the Primary Contractors and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that timeframe. The three-year period is alternatively referred to as the Active Review period. The substandards from RY 2022, RY 2021, and RY 2020 provided the information necessary for the 2022 assessment. Those triennial standards not reviewed through the system in RY 2022 were evaluated on their performance based on RY 2021 and/or RY 2020 determinations, or other supporting documentation, if necessary. For those HC-OEs that completed their Readiness Reviews within the three-year timeframe under consideration, RAI substandards were evaluated when none of the substandards crosswalked to a particular BBA category were reviewed.

For MBH, a total of 84 unique substandards were applicable for the evaluation of BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2022, 2021, 2020). In addition, 31 OMHSAS-specific substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific substandards that are not required as part of BBA regulations but are reviewed within the three-year cycle to evaluate the BH-MCO and the associated Primary Contractors against other state-specific structure and operations standards.

**Table 3.2** tallies the substandard reviews used to evaluate the 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 2020–2022). Substandard counts under RY 2022 comprised annual and triennial substandards. Substandard counts under RYs 2021 and 2020 comprised only triennial substandards. By definition, only the last review of annual substandards is counted in the three-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 117, differs from the unique count of substandards that came under active review (84).

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

| BBA Regulations | Evaluated SMART Substandards[1] | | SMART Substandards Under Active Review[2] | | |
|---|---|---|---|---|---|
| | Total | NR | 2022 | 2021 | 2020 |
| CMS EQR Protocol 3 "sections" − Standards, including Enrollee Rights and Protections | | | | | |
| Assurances of Adequate Capacity and Services (*Title 42 CFR § 438.207*) | 5 | - | 5 | - | - |
| Availability of Services (*Title 42 CFR § 438.206, Title 42 CFR § 10(h)*) | 24 | - | 14 | 4 | 6 |
| Confidentiality (*Title 42 CFR § 438.224*) | 1 | 3 | - | 1 | - |
| Coordination and Continuity of Care (*Title 42 CFR § 438.208*) | 2 | - | 2 | - | - |

| BBA Regulations | Evaluated SMART Substandards[1] | | SMART Substandards Under Active Review[2] | | |
|---|---|---|---|---|---|
| | Total | NR | 2022 | 2021 | 2020 |
| Coverage and Authorization of Services (*Title 42 CFR § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114*) | 4 | - | 4 | - | - |
| Disenrollment Requirements and Limitations (*Title 42 CFR § 438.56*) | 1 | - | - | 1 | - |
| Emergency and Post-Stabilization Services (*Title 42 CFR § 438.114*) | 5 | - | 5 | - | - |
| Enrollee Rights Requirements (*Title 42 CFR § 438.100*) | 6 | - | 1 | - | 5 |
| Health Information Systems (*Title 42 CFR § 438.242*) | 2 | 4 | - | 2 | - |
| Practice Guidelines (*Title 42 CFR § 438.236*) | 6 | - | 2 | 4 | - |
| Provider Selection (*Title 42 CFR § 438.214*) | 3 | - | - | - | 3 |
| Subcontractual Relationships and Delegation (*Title 42 CFR § 438.230*) | 8 | - | - | 8 | - |
| CMS EQR Protocol 3 "sections" – Quality Assessment and Performance Improvement Program | | | | | |
| Quality Assessment and Performance Improvement Program (*Title 42 CFR § 438.330*) | 33 | - | 19 | 8 | 6 |
| CMS EQR Protocol 3 "sections" – Grievance System | | | | | |
| Grievance and Appeal Systems (*Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424*) | 17 | - | 17 | - | - |
| Total | 117 | 7 | 69 | 28 | 20 |

[1] The total number of substandards required for the evaluation of Primary Contractor/BH-MCO compliance with the BBA regulations. Any substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/BH-MCO.
[2] The number of substandards that came under active review during the cycle specific to the review year. Because substandards may crosswalk to more than one category, the total tally of substandard reviews, 117, differs from the unique count of substandards that came under active review (84).
BBA: Balanced Budget Act; MBH: Magellan Behavioral Health; SMART: Systematic Monitoring, Access, and Retrieval Technology; NR: substandards not reviewed; CMS: Centers for Medicare & Medicaid Services; EQR: external quality review; CFR: Code of Federal Regulations; §: section.

## Determination of Compliance

To evaluate Primary Contractor/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant SMART substandards by provision (category) and evaluated the Primary Contractors' and BH-MCO's compliance status with regard to the SMART substandards. Each substandard was assigned a value of "compliant," "partially compliant," or "non-compliant" in the SMART application submitted by PA. If a substandard was not evaluated for a particular Primary Contractor/BH-MCO, it was assigned a value of "not reviewed." Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the SMART items linked to each provision. If all items were met, the Primary Contractor/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the Primary Contractor/BH-MCO was evaluated as partially compliant. If all items were not met, the Primary Contractor/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 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, *Title 42 CFR § 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.[Error! Bookmark not defined.] 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; 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 Primary Contractor/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 documents.

## Findings

Eighty-four unique substandards were used to evaluate MBH and its Primary Contractors' compliance with BBA regulations in RY 2022.

### 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 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 (*Title 42 CFR § 438.207*) | 5 | Compliant | All MBH Primary Contractors | 1.1, 1.2, 1.4, 1.5, 1.6 | - | - |
| Availability of Services (*Title 42 CFR § 438.206*) | 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 (*Title 42 CFR § 438.224*) | 1 | Compliant | All MBH Primary Contractors | 120.1 | - | - |
| Coordination and Continuity of Care (*Title 42 CFR § 438.208*) | 2 | Compliant | All MBH Primary Contractors | 28.1, 28.2 | - | - |

| Federal Category and CFR Reference | Category Substandard Count | MCO Compliance Status | Primary Contractor | Substandard Status | | |
|---|---|---|---|---|---|---|
| | | | | Fully Compliant | Partially Compliant | Not Compliant |
| Coverage and Authorization of Services (*Title 42 CFR § 438.210(a–e), § 441, Subpart B, and § 438.114*) | 4 | Compliant | All MBH Primary Contractors | 28.1, 28.2, 72.1, 72.2 | - | - |
| Disenrollment Requirements and Limitations (*Title 42 CFR § 438.56*) | 1 | Compliant | All MBH Primary Contractors | 120.1 | - | - |
| Emergency and Post-Stabilization Services (*Title 42 CFR § 438.114*) | 5 | Compliant | All MBH Primary Contractors | 72.2, 91.3, 91.5, 91.7, 91.9 | - | - |
| Enrollee Rights Requirements (*Title 42 CFR § 438.100*) | 6 | Compliant | All MBH Primary Contractors | 11.2, 24.3, 24.4, 24.5, 24.6, 72.2 | - | - |
| Health Information Systems (*Title 42 CFR § 438.242*) | 2 | Compliant | All MBH Primary Contractors | 120.1, 141.1 | - | - |
| Practice Guidelines (*Title 42 CFR § 438.236*) | 6 | Compliant | All MBH Primary Contractors | 28.1, 28.2, 93.1, 93.2, 93.3, 93.4 | - | - |
| Provider Selection (*Title 42 CFR § 438.214*) | 3 | Compliant | All MBH Primary Contractors | 10.1, 10.2, 10.3 | - | - |
| Subcontractual Relationships and Delegation (*Title 42 CFR § 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; CFR: Code of Federal Regulations; MBH: Magellan Behavioral Health; §: section.

There are 12 categories within Standards, including Enrollee Rights and Protections. MBH and its Primary Contractors were compliant with all 12 categories.

There were 67 substandard-reviews for MBH and its Primary Contractors within Compliance with Standards, including Enrollee Rights and Protections. MBH and its Primary Contractors were compliant in all 67 reviews. Some substandards apply to more than one BBA category. As a result, one partially compliant or non-compliant rating for an individual substandard could result in several BBA categories with partially compliant or non-compliant ratings.

## Quality Assessment and Performance Improvement Program

The general purpose of the regulations included under this subpart is to ensure that all services available under PA's MMC program, the HC Program, are available and accessible to MCO enrollees. The documents 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 (*Title 42 CFR § 438.330*) | 33 | Partially compliant | Bucks County, Lehigh County, Montgomery County, Northampton County | 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, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 100.1, 104.1, 104.2, 104.3, 104.4, 108.2, 108.5, 108.6, 108.7, 108.8, 108.10 | - | - |
| | | | Cambria County | 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, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 100.1, 104.1, 104.2, 104.3, 104.4, 108.2, 108.5, 108.7, 108.8, 108.10 | - | 108.6 |

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

For this review, 33 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 33 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with 32 substandards and non-compliant with one substandard.

### *Quality Assessment and Performance Improvement Program*

MBH and its Primary Contractors were partially compliant with Quality Assessment and Performance Improvement Program due to non-compliance with Substandard 6 of Standard 108 (RY 2020).

**Standard 108:** The County Contractor/BH-MCO:

a. Incorporates consumer satisfaction information in provider profiling and quality improvement process.
b. Collaborates with consumers and family members in the development of an annual satisfaction survey that meets the requirements of PS&R Appendix L.
c. Provides the Department with Quarterly and Annual summaries of consumer satisfaction activities, consumer issues identified and resolution to problems.
d. Provides an effective problem identification and resolution process.
   **Substandard 6:** The problem resolution process specifies the role of the County, BH-MCO, C/FST and providers, and results in timely follow-up of issues identified in quarterly surveys.

## Grievance System

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The 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 (*Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424*) | 17 | Partially compliant | All MBH Primary Contractors | 60.1, 60.2, 60.3, 71.2, 72.1, 72.2 | 68.1, 68.2, 68.4, 71.1, 71.4, 71.7 | 68.3, 68.7, 68.9, 71.3, 71.9 |

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

For this review, 17 substandards were crosswalked to Grievance System. All 17 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with six substandards, partially compliant with six substandards, and non-compliant with five substandards.

### *Grievance and Appeal Systems*

MBH was partially compliant with Grievance and Appeal Systems due to partial compliance with Substandard 1, Substandard 2, and Substandard 4 of Standard 68 (RY 2022); partial compliance with Substandard 1, Substandard 4, and Substandard 7 of Standard 71 (RY 2022); non-compliance with Substandard 3, Substandard 7, and Substandard 9 of Standard 68 (RY 2022); and non-compliance with Substandard 3 and Substandard 9 of Standard 71 (RY 2022)

**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 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 2:** Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.

**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).

**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:

- Internal
- External
- Expedited
- Fair Hearing

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

**Substandard 7:** Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.

**Standard 68:** See Standard description and determination of compliance under Grievance and Appeal Systems.

**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 7:** Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.

**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:** See Standard description and determination of compliance under Grievance and Appeal Systems.

**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 as to where the documentation can be obtained for review.

# IV: Validation of Network Adequacy

## Objectives

As set forth in *Title 42 CFR § 438.358*, validation of network adequacy is a mandatory EQR activity. Title 42 CFR § 438.68(a) requires states that contract with an MCP to deliver services, as well as develop, monitor, and enforce network adequacy standards consistent with the requirements under *Title 42 CFR § 438.68(b)(1)(iii)* and *§ 457.1218*. For BH, those requirements include: applying 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.[8] The EQRO is expected to validate network adequacy reporting for each MCP that assesses the confidence level of network adequacy findings for each applicable standard. EQRO validation is limited to assessment of the validity of network adequacy findings and does not include assessment of the network adequacy standards themselves. The purpose of this section is to report the EQRO's validation assessment of network adequacy findings for the BH-MCO and its associated Primary Contractors. In accordance with the updates to the CMS EQRO protocols released in February 2023,[Error! Bookmark not defined.] the EQRO is to conduct six activities, as outlined in **Table 4.1**.

Table 4.1: Network Adequacy Validation Activities

| Activity | Category |
|---|---|
| Define the scope of the validation | Planning |
| Identify data sources for validation | Planning |
| Review information systems | Analysis |
| Validate network adequacy | Analysis |
| Communicate preliminary findings to MCO | Reporting |
| Submit findings to the state | Reporting |

MCO: managed care organization.

Starting in February 2024, states must have in place a network adequacy monitoring and reporting program that stipulates state standards for the applicable plan type and corresponding quantitative indicators for network adequacy and collects data, analyzes those data, and reports findings on network adequacy on a regular basis. Regardless of whether network adequacy monitoring and reporting is conducted by the MCO or the state, the EQRO is expected to assess the validity of data collected on each applicable indicator, as well as the validity of the analyses and resulting findings. While MY 2022 predates the publication of the February 2023 protocol, IPRO was able to work with PA OMHSAS on the six EQR activities. These activities enumerated the relevant standards and corresponding indicators that were in effect in MY 2022, collected MY 2022 results, and, finally, assessed the validity of those results.

## Technical Methods of Data Collection and Analysis

IPRO gathered information from PA OMHSAS to conduct preliminary network adequacy validation activities using worksheets 4.1, 4.2, and 4.3 of the 2023 CMS EQR protocols. PA OMHSAS completed the three worksheets, which listed and described: the network adequacy standards that were in effect for the MY (Worksheet 4.1), the quantitative indicators used to assess compliance with the network adequacy standards (Worksheet 4.2), and the data source(s) used for each indicator (Worksheet 4.3). IPRO supplemented this information using results from an ISCA conducted on the MCO in 2023. Using this information, IPRO then assessed the data sources and data collection procedures for validity, including measurement validity, accuracy, and completeness. For MY 2022, network adequacy monitoring and reporting were carried out by PA using its Medicaid Enterprise Monitoring Module (MEMM) to collect and analyze data, submitted by the MCO, on geographic access by provider type. Results are compared to its network adequacy standards and recorded in its SMART compliance application at the Primary Contractor level. An extract of the SMART data for MY 2022 was then shared with IPRO.

## Description of Data Obtained

**Table 4.2** summarizes the state network adequacy standards that were applicable to BH-MCOs and their Primary Contractors in MY 2022, the frequencies of data reporting by the MCO, and corresponding network adequacy indicators.

Table 4.2 BH-MCO Network Adequacy Standards and Indicators Applicable in MY 2022

| Network Adequacy Standard | Applicable Provider Type | Data and Documentation Submitted by MCO (Frequency) | Network Adequacy Indicator |
|---|---|---|---|
| The Primary Contractor and its BH-MCO must maintain a Provider network for all Members which is geographically accessible to Members. All levels of care must be accessible in a timely manner. Members must have a choice of at least two Providers. | Intensive Behavioral Health Services | Provider network data files (weekly) | Proportion of members living in an urban designated county who have access to each level of care within 30 minutes travel time from their residence; proportion of members living in a rural designated county who have access to each level of care within 60 minutes travel time from their residence. |
| | Clozaril Support | Provider network data files (weekly) | |
| | Medically Managed Intensive Inpatient Services (ASAM Level 4) | Provider network data files (weekly) | |
| | Medically Managed Intensive Inpatient Withdrawal Management (ASAM Level 4 WM) | Provider network data files (weekly) | |
| | Drug and Alcohol Methadone Maintenance | Provider network data files (weekly) | |
| | Drug and Alcohol Outpatient | Provider network data files (weekly) | |
| | Family Based Mental Health Services | Provider network data files (weekly) | |
| | Inpatient Psychiatric – Adult | Provider network data files (weekly) | |
| | Inpatient Psychiatric – Child/Adolescent | Provider network data files (weekly) | |
| | Mental Health Crisis Intervention | Provider network data files (weekly) | |
| | Mental Health Outpatient (Psychiatric Clinic) | Provider network data files (weekly) | |
| | Mental Health Partial Hospitalization – Child/Adolescent | Provider network data files (weekly) | |
| | Peer Support | Provider network data files (weekly) | |
| | Residential Treatment Facility (RTF) | Provider network data files (weekly) | |
| | Targeted Case Management (TCM) | Provider network data files (weekly) | |
| | Center of Excellence (OUD Treatment) | Provider network data files (weekly) | |

BH-MCO: behavioral health managed care organization; ASAM: American Society of Addiction Medicine; WM: withdrawal management.

## Findings

One network adequacy indicator for each applicable provider type was used by PA OMHSAS to measure compliance by the MCO and its Primary Contractors on the network adequacy standard that was in place in MY 2022. IPRO's ISCA of MBH in MY 2022 revealed MBH utilizes Quest Analytics® Suite software and reporting to monitor provider network adequacy across geographic areas. The ISCA showed that MBH adequately met Information Systems utility requirements for reviewing provider network adequacy. The provider network data files are submitted to PA's MEMM and subsequently analyzed each year by OMHSAS to calculate rates for the network adequacy indicator for each provider category. These results are then recorded under Primary Contractor results for Substandard 1.2 in the SMART application:

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

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

For MY 2022, MBH and all of its Primary Contractors were found to be fully compliant (for all provider categories) with Standard 1.2 and the corresponding network adequacy standard.

After review of the relevant ISCA findings, network adequacy data, and methods, IPRO has high confidence in the validity of these MY 2022 results.

# V: Quality Studies

## Objectives

The purpose of this section is to describe quality studies performed in 2022 for the HC population. The studies are included in this report as optional EQR activities that occurred during the RY.[Error! Bookmark not defined.]

### Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the Certified Community Behavioral Health Clinic (CCBHC) Demonstration but to continue and build on the CCBHC model in a PA DHS-administered 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, BH 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 remaining four 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 HC MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the following original seven clinics were invited to participate in the new program: 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).

## 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 that feeds, on a weekly basis, a server-based Tableau workbook in which clinics are able to monitor progress on the implementation of their ICWC model. Using the dashboard, clinics in 2022 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 2022, the number of individuals receiving at least one core service dropped to 15,345 from 22,690 in 2021. The unweighted average (across all the clinics) of the number of days until initial evaluation increased to 12.4 days from 10.8 days in 2021. In the area of depression screening and follow-up, 89% of positive screenings resulted in the documentation of a follow-up plan the same day. A little over 2,700 individuals within the ICWC program received drug and alcohol outpatient or intensive outpatient treatment during the period, down 50% from 5,400 in 2021.

Process measures reflect important progress in increasing both the access and quality of community-based care for individuals with BH 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 CY basis, along with the HEDIS FUI measure. **Table 5.1** summarizes how well the ICWC clinics performed 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 CY 2022 Weighted Average | Comparison | |
|---|---|---|---|
| | | ICWC CY 2022 Performance Target | Benchmark Performance |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 7 day | 13.0% | 32.5% | Between the 5th and 10th percentiles of the HEDIS 2023 Quality Compass |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 30 day | 21.0% | 53.8% | Below the 5th percentile of the HEDIS 2023 Quality Compass |
| Follow-Up Care for Children Prescribed ADHD Medication (ADD) − Initiation | 66.0% | 80.2% | Above the 95th percentile of the HEDIS 2023 Quality Compass |
| Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Continuation and Maintenance | 75.0% | 81.5% | Above the 95th percentile of the HEDIS 2023 Quality Compass |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) − 7 day | 43.8% | 26.7% | Between the 90th and 95th percentiles of the HEDIS 2023 Quality Compass |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) − 30 day | 66.7% | 39.0% | Above the 95th percentile of the HEDIS 2023 Quality Compass |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) − 7 day | 100% | 100% | Above the 95th percentile of the HEDIS 2023 Quality Compass |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) − 30 day | 100% | 100% | Above the 95th percentile of the HEDIS 2023 Quality Compass |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 years − Initiation | 21.9% | N/A | Below the 5th percentile of the HEDIS 2023 Quality Compass |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 years − Engagement | 7.2% | N/A | Between the 10th and 25th percentiles of the HEDIS 2023 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 18–64 years (FUH-A) − 7 day | 10.6% | 30.2% | Below the 5th percentile of the HEDIS 2023 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 18–64 years (FUH-A) − 30 day | 19.1% | 41.6% | Below the 5th percentile of the HEDIS 2023 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 6–17 years (FUH-C) − 7 day | 19.5% | 43.8% | Between the 5th and 10th percentiles of the HEDIS 2023 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 6–17 years (FUH-C) − 30 day | 28.3% | 55.6% | Below the 5th percentile of the HEDIS 2023 Quality Compass |
| Antidepressant Medication Management (AMM) − Acute | 56.1% | 62.5% | Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass |

| Measure | ICWC CY 2022 Weighted Average | Comparison | |
|---|---|---|---|
| | | ICWC CY 2022 Performance Target | Benchmark Performance |
| Antidepressant Medication Management (AMM) - Continuation | 39.8% | 38.5% | Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) | 55.9% | 62.1% | Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) | 77.3% | 85.0% | Between the 25th and 33rd percentiles of the HEDIS 2023 Quality Compass |
| Plan All-Cause Readmissions Rate (PCR) – Observed Rate | 30.0% | 3.8% | N/A (HEDIS 2023 Quality Compass Observed Rate benchmarks not available) |
| Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) | 59.5% | 100% | Between the 70th and 80th percentiles of the MIPS 2023 (eCQM) |
| Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) | 32.2% | 100% | Between the 50th and 60th percentiles of the MIPS 2023 (eCQM) |
| Screening for Depression and Follow-Up Plan (CDF-BH) | 36.8% | 47.5% | Between the 50th and 60th percentiles of the MIPS 2023 (eCQM) |
| Depression Remission at Twelve Months (DEP-REM-12) | 63.3% | 15.0% | Above the 95th percentile of the MIPS 2023 (eCQM) |
| Body Mass Index (BMI) Screening and Follow-Up Plan | 42.7% | 62.5% | Between the 10th and 20th percentiles of the MIPS 2023 (eCQM) |
| Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH) | 63.9% | 80.0% | Between the 80th and 90th percentiles of the MIPS 2023 (eCQM) |
| Tobacco Use: Screening and Cessation Intervention (TSC) | 87.4% | N/A | Between the 60th and 70th percentiles of the MIPS 2023 (CQM) |
| Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) | 65.5% | N/A | Between the 50th and 60th percentiles of the MIPS 2023 (CQM) |

ICWC: Integrated Community Wellness Center; HEDIS: Healthcare Effectiveness Data and Information Set; ADHD: attention deficit/hyperactivity disorder; MIPS: Merit-Based Incentive Pay System; eCQM: electronic clinical quality measure; CQM: clinical quality measure; N/A: not applicable, no performance target was set for measurement year 2022.

Quality measures where the ICWC clinics met or surpassed targets include: Follow-Up After Emergency Department Visit for Mental Illness (FUM), Antidepressant Medication Management (AMM) − Continuation, and Depression Remission at Twelve Months (DEP-REM-12).

# VI: MCO Responses to 2022 EQR Recommendations

## 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 2022 (MY 2021) EQR annual technical report and in the 2023 (MY 2022) FUH All Ages Goal Report.

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 PA 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, 2023, 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 September 2023 to address partial and non-compliant 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 2021 underperformance in the HEDIS FUH All Ages measures was distributed, along with the MY 2021 results, in January 2023. The RCA and QIP form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed QIP to address those factors, complete with a timeline of implementation, monitoring, and reporting activities. BH-MCOs submitted their responses by March 17, 2023, and the Primary Contractors submitted their responses by March 31, 2023.

## Quality Improvement Plan for Partial and Non-compliant SMART 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 2021, MBH began to address opportunities for improvement related to compliance categories within two of the three CMS sections pertaining to compliance with MMC regulations. Within Compliance with Standards, including Enrollee Rights and Protections, MBH was partially compliant with Coverage and Authorization of Services. 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.

The embedded document presents MBH's responses to opportunities for improvement cited by IPRO in the 2022 (MY 2021) EQR annual technical report, detailing current and proposed interventions. Original references to "PEPS" have been replaced with "SMART." Objects originally embedded within the MCO response have been removed as exhibits. The entire MCO response is available upon request.

Frm_2023 BH Opps Response Request_M

## Root Cause Analysis and Quality Improvement Plan

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

- a goal statement;
- RCA 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.

In 2023, OMHSAS made a few important changes to the PM remediation process. First, it added REA to the process by requiring BH-MCOs and Primary Contractors to submit QIPs for rates above the statewide goal of 11.75%. BH-MCOs assigned a QIP are also required to complete an RCA that informs their QIP. Furthermore, QIPs must address any racial or ethnic disparities in PM rates. Finally, OMHSAS extended the timeframe of RCAs and QIPs to every two years. This is designed to give interventions more time to work while reducing the administrative burden.

In MY 2022, MBH scored below the HEDIS Quality Compass 75th percentile on both the HEDIS FUH 7-day and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. MBH's REA rate was above the 11.75% benchmark and was therefore also required to complete and RCA and QIP to address REA.

The embedded documents present MBH's responses to opportunities for improvement cited by IPRO in the 2022 (MY 2021) EQR annual technical report, detailing current and proposed interventions. Objects originally embedded within the MCO response have been removed as exhibits. The entire MCO response is available upon request.


HEDIS All Ages 7-Day FUH RCA and QIP Res


HEDIS All Ages 30-Day FUH RCA and


30-Day Readmission REA RCA and QIP Res

# VII: 2023 Strengths, Opportunities for Improvement, and Recommendations

This section provides an overview of MBH's MY 2022 performance with identified strengths and opportunities for improvement in the following areas: structure and operations standards, PIPs, and PMs. 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, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity, as described in *Title 42 CFR 438.310(c)(2)*.

## Strengths

- MBH's MY 2022 HEDIS 7-day FUH rates (QI 1) for members ages 6−17 years and overall increased from MY 2021, and the change was statistically significant.
- MBH's MY 2022 REA rate decreased (improved) from MY 2021, and the change was statistically significant.
- Review of compliance with MMC regulations conducted by PA in RY 2020, RY 2021, and RY 2022 found MBH to be fully compliant with Standards, including Enrollee Rights and Protections.

## Opportunities for Improvement

- Based on review of MBH's Year 2 PIP report, there is moderate confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results.
- There is moderate confidence that the PIP produced evidence of significant improvement.
- MBH's MY 2022 HEDIS 30-day FUH rates (QI 2) for members ages 18−64 years fell from MY 2021, and the change was statistically significant.
- MBH's MY 2022 HEDIS 7-day and 30-Day FUH rates (QI 1 and QI 2) for ages 18–64 years and ages 6+ years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- Review of Compliance with Standards conducted by PA in RY 2020, RY 2021, and RY 2022 found MBH to be partially compliant with two sections associated with MMC regulations:
    - MBH was partially compliant with the single category of Quality Assessment and Performance Improvement Program.
    - MBH was partially compliant with the single category of Grievance and Appeal Systems within Grievance System.

## Assessment of Quality, Timeliness, and Access

Responsibility for **quality** of, **timeliness** of, and **access** to health care services and supports is distributed among providers, payers, and Primary Contractors. Due to the BH carve-out within PA's HC program, BH-MCOs and physical health managed care organizations (PH-MCOs) operate under separate contracts, with BH-MCOs contracting with non-overlapping Primary Contractors, making this distribution even more complex. However, when it comes to improving healthcare quality, timeliness, and access, the BH-MCO can focus on factors within its 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 MY 2022. The PIP recommendations may include issues from prior years if they remain unresolved. For PMs, the strengths and opportunities noted above in this section summarize findings from the current report, while recommendations are based on issues that were not only identified as opportunities from the current report but were also identified as outstanding opportunities from last year's EQR technical report.

Table 7.1: EQR Recommendations

| EQR Task/Measure | MY 2021 Recommendation | MY 2022 Finding | MY 2022 Recommendation | Standards |
|---|---|---|---|---|
| Performance Improvement Projects (PIPs) | | | | |
| Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders | Opportunities for improvement were limited to clarifying discussion of preliminary findings. | Based on review of MBH's Year 2 report, there is moderate confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results (Rating 1). The validation findings generally indicate that the credibility of the PIP results is not at risk. However, results must be interpreted with some caution.<br><br>There is moderate confidence that the PIP produced evidence of significant improvement (Rating 2). SAR rates showed improvement over Year 1, while MHR rates did not (after improving over baseline). All other performance indicator rates (FUI, MAT-AUD, and MAT-OUD) worsened since Year 1. | As relates to Finding 1, IPRO recommends the following:<br>• MBH should implement at least one performance indicator of its general population (community prevention) objectives. The relative participation of CRS services among African American and Hispanic members could serve this role for Objective 6; however, the Objective 5 related to prevention and early detection would seem to suggest the need for another measure. One possibility is for MBH to run an administrative measure of SBIRT or similar screening encounters, albeit one limited to its own enrolled members. This carries the advantage of being able to retroactively calculate a 2020 baseline. Another possibility is an education and outreach campaign with community-based providers and recovery supports to address the lingering stigma attached to pharmacotherapy (e.g., among certain AA groups), which would help address a barrier to improving MAT rates. Such a measure could be operationalized in the form of a survey or questionnaire.<br><br>As relates to Rating 2, IPRO recommends the following:<br>• MBH makes a strong case for expecting improvement down the line based on steady improvements in many of its ITMs, which serve as useful leading indicators. Actualization of those improvements, however, will depend on continued effort, vigilance, and a readiness to adjust if needed. | Quality, Timeliness, Access |

| EQR Task/Measure | MY 2021 Recommendation | MY 2022 Finding | MY 2022 Recommendation | Standards |
|---|---|---|---|---|
| Performance Measures | | | | |
| HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) | Although MBH's FUH rate fell slightly in MY 2021, the decrease was smaller than the Statewide drop. 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." | Overall, MY 2022 saw mixed results for MBH and its Primary Contractors with respect to FUH rates. MBH's HEDIS FUH overall (all ages) 7-day rate increased, led by Cambria County, and the improvement was statistically significant, while the HEDIS FUH 30-day rate significantly improved for the ages 18−64 years group. The most striking improvement, however, was in the ages 6−17 years group, which saw a 12.6 percentage point jump, led by Cambria, Lehigh, and Montgomery counties. Still, MBH's HEDIS FUH all ages rates were below the HEDIS Quality Compass 75th percentiles.<br><br>MBH's comprehensive RCAs and QIPs for its HEDIS 7-day and 30-day FUH rates demonstrates that the MCO and its Primary Contractors have a solid grasp of the multidimensional drivers of their FUH rates, including staff shortages, especially at inpatient facilities that impede communications and workflows (especially related to discharge planning); network adequacy for certain provider types that may lead to longer wait | IPRO concurs with MBH's proposed remediations outlined in its QIPs which, taken together, provide a multipronged response. These include innovative VBP arrangements ranging in scope from inpatient facilities to peer and recovery support providers, automation of CM workflows with trigger points for SDoH-positive screens or other adverse results, expansion of Project RED, internal and external audits ranging from record reviews to reviews of trauma-informed care, and enhanced telehealth supports.<br><br>Related to the ethnic disparity finding, IPRO recommends MBH incorporate consideration of any disparities into their RCAs and QIPs, even if disparities appear to favor non-majority groups, as the goal ultimately is to eliminate health care disparities in general. One way to do this is to consider including other variables in statistical models, such as urban versus rural residence. This may in turn reveal deeper causes that suggest effective responses. | Timeliness, Access |

| EQR Task/Measure | MY 2021 Recommendation | MY 2022 Finding | MY 2022 Recommendation | Standards |
|---|---|---|---|---|
| | | times or difficulty finding therapeutically aligned providers; SDoH barriers to making and keeping follow-up appointments; complex medical and BH needs of members; lack of provider understanding of how to best facilitate step-down care; and technical barriers to telehealth uptake.<br><br>MBH and its Primary Contractors reported that the Hispanic population had higher FUH rates than the non-Hispanic population, while no racial disparities between White members and non-White members were detected in MY 2022. | | |
| PA FUH | MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project 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 | MBH's PA-specific FUH fell slightly, but the change was not statistically significant. The biggest drop occurred in Delaware County, which changed contracts to CCBH on July 1, 2022. | See HEDIS FUH. | Timeliness, Access |

| EQR Task/Measure | MY 2021 Recommendation | MY 2022 Finding | MY 2022 Recommendation | Standards |
|---|---|---|---|---|
| | independence and self-management." | | | |
| Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) | MBH's REA rate improved (decreased) significantly from MY 2020 by 1.6 percentage points. For their 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 as complex chronic disease management of comorbid conditions. MBH's multifaceted approach in its PIP targeting both member engagement but also provider training and network enhancements places the MCO in a strong position to decrease readmission rates after hospitalization for mental illness for members who also have SUD. A next logical step is to conduct Difference in Difference (DiD) tests to compare rates of improvement in REA between members who carry an SUD diagnosis and those who don't to assess whether PIP interventions are being effective. Similar analysis could be conducted for members with SPMI who are participating in the ICP program (and compared to those who are not) to determine | MBH's REA rates improved, led by Bucks and Northampton counties, and the decrease in rates was statistically significant. MBH fell just short (above) the statewide goal of 11.75%.<br><br>MBH's RCA and QIP for its REA, which fell just short of the statewide goal, addresses many of the factors identified for low FUH rates while also addressing factors specific to readmissions. For example, in results seen elsewhere, MBH identified a relatively small cohort of members contributing a large share of the psychiatric readmissions. MBH notes that this group may respond well to peer support and/or enhanced case management services, provided they are successfully engaged. MBH's ongoing and planned interventions overlap with those concerned with FUH while also addressing readmission-specific issues, such as cultural education and training for member-facing staff and eventually providers.<br><br>For MY 2022, MBH found that African American/Black | MBH should continue to engage with its logic models of change, making sure that data are being collected at appropriate frequencies along all the important points of the chains of causation so that hypotheses about what is or is not working can be made and tested. Insights from those analyses can then be used to inform recalibrations of interventions or, if necessary, of the logic models themselves. | Timeliness, Access |

| EQR Task/Measure | MY 2021 Recommendation | MY 2022 Finding | MY 2022 Recommendation | Standards |
|---|---|---|---|---|
| | whether specific BH-PH integration interventions are also impacting REA. | members were less likely to obtain follow-up care, as measured by FUH, compared to White members, and this disparity appeared to be most pronounced in males. MBH speculates this may be related to cultural factors such as stigma, as well as a lack of practitioners in the network who are African American/Black, compounded by poor prior experiences with the health care system in general. MBH did not find any ethnic health disparities in MY 2022 REA rates. | | |
| 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 and timelines. In 2021 MBH showed an improvement in use of the correct template, but OMHSAS noted an area for improvement is ensuring the effective date is correct based upon the type of request made. IPRO concurs with OMHSAS' recommendation: MBH must ensure Denial Letters are mailed to the Member at least ten (10) days prior to the effective date of the denial of authorization for continued services. | MBH became fully compliant with this category. | No recommendations. | Quality, Timeliness, Access |

| EQR Task/Measure | MY 2021 Recommendation | MY 2022 Finding | MY 2022 Recommendation | Standards |
|---|---|---|---|---|
| Quality Assessment and Performance Improvement (QAPI) Program | MBH was compliant. | MBH was partially compliant with QAPI due to non-compliance by Cambria county on a substandard that was reviewed in 2020 but newly crosswalked to the QAPI category. Interviews with the CFST Director and CFST staff revealed that policies and procedures were not developed and implemented in a manner that clearly described the process for resolution of issues and that identified those responsible for follow-up and how the resolution of issues should be monitored to ensure responsiveness. | IPRO concurs with OMHSAS: Corrective Action Required – Cambria should create a policy and procedure that describes the process for resolution of issues and identifies those responsible for follow-up and how the resolution of issues will be monitored to ensure responsiveness. This should clearly outline the role that the CFST program will take in this process. Furthermore, Cambria should create a policy that outlines resolution process that outlines the CFST Program's involvement in the follow-up process. | 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 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 | MBH was partially compliant with Grievance and Appeal Systems standard due to deficiencies generally concerned with the complaint and grievance processes. MBH was partially compliant with five substandards and non-compliant with five substandards. | IPRO concurs with OMHSAS's recommendations, some of which continue from last year and include: ensure completed sign-in sheets for 1st and 2nd level Complaint and Grievance reviews for all reviews; ensure decision letters are clear and concise; follow up with members to ascertain satisfaction of process; monitor case files for completeness and report issues to Primary Contractors as needed; adhere to Appendix H timelines; improve documentation in case notes; and define explicit criteria to trigger onsite provider reviews or other follow-up actions. | Quality, Timeliness, Access |

| EQR Task/Measure | MY 2021 Recommendation | MY 2022 Finding | MY 2022 Recommendation | Standards |
|---|---|---|---|---|
| | 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; MBH: Magellan Behavioral Health; MY: measurement year; CCBH: Community Care Behavioral Health; MY: measurement year; FUI: Follow-Up After High-Intensity Care for Substance Use Disorder; MAT-OUD: Medication-Assisted Treatment for Opioid Use Disorder; MHR: Mental Health-Related Avoidable Readmissions; SAR: Substance Use Disorder-Related Avoidable Readmissions; MAT-AUD: Medication-Assisted Treatment for Alcohol Use Disorder; ITM: intervention tracking measure; RCA: root cause analysis; QIP: quality improvement plan; SUD: substance use disorder; PA: Pennsylvania; VBP: value-based payment; HEDIS: Healthcare Effectiveness Data and Information Set; OMHSAS: Office of Mental Health and Substance Abuse Services; SDoH: social determinants of health; CM: care management; SPMI: serious persistent mental illness; BH: behavioral health; PH: physical health; CRS: certified recovery specialist; AA: Alcoholics Anonymous; SBIRT: screening, brief intervention, and referral to treatment; AWOL/AMA: Absence without leave/Against medical advice; ICP: Integrated Care Plan; C/FST: Consumer/Family Satisfaction Team.

# VIII: Summary of Activities

## Validation of Performance Improvement Projects

- MBH successfully implemented their PEDTAR PIP for MY 2022.

## Validation of Performance Measures

- MBH reported all PMs and applicable quality indicators for MY 2022.

## Compliance with Medicaid Managed Care Regulations

- MBH was fully compliant with Standards, including Enrollee Rights and Protections. MBH was partially compliant with Quality Assessment and Performance Improvement Program and Grievance System. As applicable, compliance review findings from RY 2022, RY 2021, and RY 2020 were used to make the determinations.

## Validation of Network Adequacy

- MBH was compliant with all network adequacy standards in MY 2022, and the findings were assigned a validity rating of high confidence.

## Quality Studies

- For any of its members receiving ICWC services in MY 2022, MBH covered those services under a Prospective Payment System rate.

## MCO Responses to 2022 EQR Recommendations

- MBH provided a response to the opportunities for improvement issued in 2022.

## 2023 Strengths, Opportunities for Improvement, and Recommendations

- Both strengths and opportunities for improvement were noted for MBH in 2023 (MY 2022). The BH-MCO will be required to prepare a response in 2024 for the noted opportunities for improvement.

# References

[1] Code of Federal Regulations, Title 42: Public Health. (2022, March 8). Title 42 CFR § 438.358 – Activities related to external quality review. eCFR: Home.

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# Appendix A. Required SMART Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for required SMART substandards pertinent to BBA Regulations.

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

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| Assurances of Adequate Capacity and Services (*Title 42 CFR § 438.207*) | 1.1 | Updated Provider Network Report, to include the following: A completed listing of all contracted and credentialed providers; Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standards 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. |
| | 1.2 | 100% of members are given a choice of 2 providers at each level of care within 30/60 urban/rural met |
| | 1.4 | The BH-MCO has identified and addressed any gaps in provider network (e.g. cultural, special priority, needs populations or specific services) |
| | 1.5 | The BH-MCO has notified the Department of any drop in provider network. Monitor provider turnover. Network remains open where needed |
| | 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 (*Title 42 CFR § 438.206, Title 42 CFR § 10(h)*) | 1.1 | Updated Provider Network Report, to include the following: A completed listing of all contracted and credentialed providers; Maps to demonstrate 30 minutes (20 miles) urban, and 60 minutes (45 miles) rural access timeframes (the mileage standards 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. |
| | 1.2 | 100% of members are given a choice of 2 providers at each level of care within 30/60 urban/rural met |
| | 1.3 | Provider exception report submitted and approved when choice of two providers is not given |
| | 1.4 | The BH-MCO has identified and addressed any gaps in provider network (e.g. cultural, special priority, needs populations or specific services) |
| | 1.5 | The BH-MCO has notified the Department of any drop in provider network. Monitor provider turnover. Network remains open where needed |
| | 1.6 | BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees |
| | 1.7 | Confirm FQHC providers |
| | 23.1 | BH-MCO has assessed if 5% requirement is applicable (see b in Standard Description) |
| | 23.2 | BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met. |
| | 23.3 | List of oral interpreters is available for non-English speakers. |
| | 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.) |
| | 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.) |
| | 24.1 | BH-MCO provider application includes information about handicapped accessibility |
| | 24.2 | Provider network database contains required information for ADA compliance |
| | 24.3 | BH-MCO phone answering uses TTY or PA telecommunication relay services |

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| | 24.4 | BH-MCO is able to access interpreter services |
| | 24.5 | BH-MCO has the ability to accommodate people who are hard of hearing |
| | 24.6 | BH-MCO can make alternate formats available upon request |
| | 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 |
| | 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 |
| | 93.1 | The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates. |
| | 93.2 | The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability. |
| | 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. |
| | 93.4 | The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction. |
| Confidentiality (*Title 42 CFR § 438.224*) | 120.1 | The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data. |
| | 142.1 | The PC/BH-MCO uses the required reference files as evidenced through correct, complete, and accurate reference information submitted on encounter data records. Diagnosis Code Files; Procedure Code Files |
| | 144.1 | 98% of Professional Encounters and 95% of Institutional Encounters submitted each month must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits). |
| | 145.1 | All encounters must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits) within 90 days following the date that the BH-MCO paid/adjudicated the provider's claim or encounter. |
| Coordination and Continuity of Care (*Title 42 CFR § 438.208*) | 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 |
| | 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 (*Title 42 CFR § 438.210(a–e)*, *Title 42 CFR 440.230*, *Title 42 CFR § 441*, Subpart B) | 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 |
| | 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 |
| | 72.1 | Denial notices are issued to members according to required timeframes and use the required template language |
| | 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 DHS 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). |

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| Disenrollment Requirements and Limitations (*Title 42 CFR § 438.56*) | 120.1 | The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data. |
| Emergency and Post-Stabilization Services (*Title 42 CFR § 438.114*) | 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 DHS 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). |
| | 91.3 | The QM Program Description includes the following basic elements:<br>a. Performance improvement projects<br>b. Collection and submission of performance measurement data<br>c. Mechanisms to detect underutilization and overutilization of services<br>d. Emphasis on, but not limited to, high volume/high-risk services and treatment, such as IBHS.<br>e. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs |
| | 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). |
| | 91.7 | The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members:<br>a. Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates.<br>b. Appropriateness of service authorizations and inter-rater reliability.<br>c. Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates.<br>d. Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction. |
| | 91.9 | The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services:<br>a. Telephone access and responsiveness rates<br>b. Overall utilization patterns and trends including IBHS and other high volume/high risk services |
| Enrollee Rights Requirements (*Title 42 CFR § 438.100*) | 11.2 | 100% of new providers have received orientation, including member rights and protection. |
| | 24.3 | BH-MCO phone answering uses TTY or PA telecommunication relay services |
| | 24.4 | BH-MCO is able to access interpreter services |
| | 24.5 | BH-MCO has the ability to accommodate people who are hard of hearing |
| | 24.6 | BH-MCO can make alternate formats available upon request |
| | 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 DHS 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). |

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| Health Information Systems (*Title 42 C.F.R. § 438.242*) | 120.1 | The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data. |
| | 141.1 | BH-MCO has met the Department's standards of clean claims each of the 12 months: 90% @ 30 days, 100% @ 45 days |
| | 142.1 | The PC/BH-MCO uses the required reference files as evidenced through correct, complete, and accurate reference information submitted on encounter data records. Diagnosis Code Files; Procedure Code Files |
| | 143.1 | The PC/BH-MCO uses the required provider files as evidenced through correct, complete, and accurate provider information submitted on encounter data records. PRV 414; PRV 415; PRV 430; PRV 435; PRV 720 |
| | 144.1 | 98% of Professional Encounters and 95% of Institutional Encounters submitted each month must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits). |
| | 145.1 | All encounters must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits) within 90 days following the date that the BH-MCO paid/adjudicated the provider's claim or encounter. |
| Practice Guidelines (Title 42 CFR § 438.236) | 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 |
| | 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 |
| | 93.1 | The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates. |
| | 93.2 | The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability. |
| | 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. |
| | 93.4 | The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction. |
| | 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 edibility BH-MCO onsite review, as applicable. |
| | 10.2 | 100% of decisions made within 180 days of receipt of application |
| | 10.3 | Recredentialing incorporates results of provider profiling |
| Provider Selection (*Title 42 CFR § 438.214*) | 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 edibility BH-MCO onsite review, as applicable. |
| | 10.2 | 100% of decisions made within 180 days of receipt of application |
| | 10.3 | Recredentialing incorporates results of provider profiling |
| Subcontractual Relationships and Delegation (*Title 42 CFR § 438.230*) | 99.1 | The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning |
| | 99.2 | The BH-MCO reports monitoring results for adverse incidents |
| | 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 |
| | 99.4 | The BH-MCO reports monitoring results for administrative compliance |

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| | 99.5 | The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals |
| | 99.6 | Provider profiles and individual monitoring results are reviewed with providers |
| | 99.7 | Providers are evaluated based on established goals and corrective action taken as necessary |
| | 99.8 | The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy |
| Quality Assessment and Performance Improvement Program (*Title 42 CFR § 438.330*) | 91.1 | The QM Program Description clearly outlines the BH-MCO QM structure |
| | 91.2 | The QM Program Description clearly outlines the BH-MCO QM content. |
| | 91.3 | The QM Program Description includes the following basic elements:<br>a. Performance improvement projects<br>b. Collection and submission of performance measurement data<br>c. Mechanisms to detect underutilization and overutilization of services<br>d. Emphasis on, but not limited to, high volume/high-risk services and treatment, such as IBHS.<br>e. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs |
| | 91.4 | The QM Work Plan includes:<br>a. Objective<br>b. Aspect of care/service<br>c. Scope of activity<br>d. Frequency<br>e. Data source<br>f. Sample size<br>g. Responsible person<br>h. Specific, measurable, attainable, realistic and timely performance goals, as applicable |
| | 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). |
| | 91.6 | The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted. |
| | 91.7 | The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members:<br>a. Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates.<br>b. Appropriateness of service authorizations and inter-rater reliability.<br>c. Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates.<br>d. Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction. |
| | 91.8 | The QM Work Plan includes a provider profiling process. |
| | 91.9 | The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services:<br>a. Telephone access and responsiveness rates<br>b. Overall utilization patterns and trends including IBHS and other high volume/high risk services |
| | 91.10 | The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network:<br>a. Quality of individualized service plans and treatment planning<br>b. Adverse incidents |

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| | | c. Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance |
| | 91.11 | The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO |
| | 91.12 | The QM Work Plan addresses PA-specific, HEDIS and other performance measures, as applicable:<br>a. Pay-for-Performance Appendix GG of PS&R – PA-specific and HEDIS FUH 7-day and 30-day and REA within 30 days of discharge<br>b. EQRO Annual Technical Report (ATR) identification of Opportunities For Improvement (OFI) for Follow up After Mental Health Hospitalization (FUH) – BH-MCO should address EQRO's identification of OFI in their Annual Workplan and Annual Evaluation<br>c. QM Annual Evaluation |
| | 91.13 | The identified performance improvement projects must include the following:<br>a. Measurement of performance using objective quality indicators<br>b. Implementation of system interventions to achieve improvement in quality<br>c. Evaluation of the effectiveness of the interventions<br>d. Planning and initiation of activities for increasing or sustaining improvement<br>e. Timeline for reporting status and results of each project to the Department of Human Services (DHS)<br>f. 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 |
| | 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 |
| | 91.15 | The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan. |
| | 93.1 | The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates. |
| | 93.2 | The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability. |
| | 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. |
| | 93.4 | The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction. |
| | 98.1 | The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate < 5%, average speed of answer < 30 seconds. |
| | 98.2 | The BH-MCO reports monitoring results for overall utilization patterns and trends, including IBHS 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. |
| | 98.3 | The BH-MCO reports monitoring results for coordination with other service agencies and schools |
| | 100.1 | The BH-MCO assesses provider satisfaction with network management; specifically: claims processing, provider relations, credentialing, prior authorization, service management and quality management |

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| | 104.1 | The BH-MCO must measure and report its performance using standard measures required by DHS |
| | 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. |
| | 104.3 | Performance Improvement Plans status reported within the established time frames |
| | 104.4 | The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly SMART Reports |
| | 108.2 | C/FST budget is sufficient to: hire staff proportionate to HealthChoices covered lives; have adequate office space; purchase equipment; travel and attend on-going training. |
| | 108.5 | The C/FST has access to providers and HealthChoices members to conduct surveys, and employs a variety of survey mechanisms to determine member satisfaction; e.g. provider specific reviews, mailed surveys, focus meetings, outreach to special populations, etc. |
| | 108.6 | The problem resolution process specifies the role of the County, BH-MCO, C/FST and providers, and results in timely follow-up of issues identified in quarterly surveys. |
| | 108.7 | The C/FST quarterly reports submitted to OMHSAS include the numeric results of surveys by provider and level of care, and narrative information about trends and actions taken on behalf of individual consumers, with providers, and systemic issues, as applicable. |
| | 108.8 | The annual mailed/telephonic survey results are representative of HealthChoices membership, and identify systemic trends. Actions have been taken to address areas found deficient, as applicable. |
| | 108.10 | The C/FST Program is an effective, independent organization that is able to identify and influence quality improvement on behalf of individual members and system improvement. |
| Grievance and Appeal Systems (*Title 42 CFR § 438.228*) | 60.1 | Table of organization identifies lead person responsible for overall coordination of Complaint and Grievance process and adequate staff to receive, process and respond to member Complaints and Grievances. |
| | 60.2 | Training rosters and training curriculums identify that Complaint and Grievance staff has been adequately trained on Member rights related to the processes and how to handle and respond to member Complaints and Grievances. |
| | 60.3 | The BH-MCO's Complaint and Grievance policies and procedures comply with the requirements set forth in Appendix H. |
| | 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.<br>• 1st level<br>• 2nd level<br>• External<br>• Expedited<br>Fair Hearing |
| | 68.2 | • Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process. |
| | 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. |

| BBA Category | SMART Reference | SMART Language |
|---|---|---|
| | 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). |
| | 68.7 | Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member. |
| | 68.9 | Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review. |
| | 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:<br>• Internal<br>• External<br>• Expedited<br>Fair Hearing |
| | 71.2 | • Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process. |
| | 71.3 | 100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | 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. |
| | 71.7 | Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member. |
| | 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 as to where the documentation can be obtained for review. |
| | 72.1 | Denial notices are issued to members according to required timeframes and use the required template language |
| | 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 DHS 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). |

SMART: Systematic Monitoring, Access, and Retrieval Technology; BBA: Balanced Budget Act; CFR: Code of Federal Regulations; §: section; DOH: Department of Health; BH: behavioral health; MCO: managed care organization; PH: physical health; FQHC: federally qualified health center; PC: Primary Contractor; HIPAA: Health Insurance Portability and Accountability Act; OMHSAS: Office of Mental Health and Substance Abuse Services; DHS: Department of Human Services; QM: quality management; HEDIS: Healthcare Effectiveness Data and Information Set; PS&R: Program Standards and Requirements; EQRO: external quality review organization; ADA: Americans with Disabilities Act; TTY: teletype; IBHS: intensive behavioral health services; MA: Medicaid; C/FST: Consumer/Family Satisfaction Team.

# Appendix B. OMHSAS-Specific SMART Substandards

Refer to **Table B.1** for OMHSAS-specific SMART substandards.

Table B.1: OMHSAS-Specific SMART Substandards

| Category | SMART Reference | SMART Language |
|---|---|---|
| Care Management | | |
| Care Management (CM) Staffing | 27.1 | BH-MCO has staffing standard for the number of care managers needed. |
| Care Management (CM) Staffing | 27.2 | Current staffing pattern is in compliance with the stated standard. |
| Care Management (CM) Staffing | 27.3 | BH-MCO care management staff represents specialty area of mental health, drug and alcohol, child and adult, and experience in the field. |
| Care Management (CM) Staffing | 27.4 | BH-MCO has a staffing standard for the number of physician and peer reviews needed. |
| Care Management (CM) Staffing | 27.5 | Current staffing pattern is in compliance with the stated standard. |
| Care Management (CM) Staffing | 27.6 | Physician and peer reviews represent specialty areas of mental health, drug and alcohol, child and adults, and experience in field. |
| Care Management (CM) Staffing | 27.7 | Other: Significant onsite review findings related to Standard 27 |
| Longitudinal Care Management (and Care Management Record Review) | 28.3 | Other: Significant onsite review findings related to Standard 28 |
| Complaints and Grievances | | |
| Complaints | 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. |
| Complaints | 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 ( facilitator documents participant’s virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent. |
| Complaints | 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. |
| Complaints | 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. |
| Complaints | 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. |

| Category | SMART Reference | SMART Language |
|---|---|---|
| Grievances | 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. |
| Grievances | 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 (facilitator documents participant's virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent. |
| Grievances | 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. |
| Grievances | 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. |
| Grievances | 71.1.2 | Training rosters and training curriculums demonstrate 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. |
| Denial | | |
| Denials | 72.3 | BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements. |
| Education and Prevention Programs | | |
| Education and prevention programs | 59.1 | BM-MCO has implemented public education and prevention programs, including behavioral health educational materials. |
| Enrollee Satisfaction | | |
| Consumer/Family Satisfaction | 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. |
| Consumer/Family Satisfaction | 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. |
| Consumer/Family Satisfaction | 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. |

| Category | SMART Reference | SMART Language |
|---|---|---|
| Executive Management | | |
| County Executive Management | 78.1 | Updated County Table of Organization − evidence of sufficient staff. |
| County Executive Management | 78.2 | 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. |
| County Executive Management | 78.3 | County formal review of BH-MCO is completed on an annual basis. |
| County Executive Management | 78.4 | There is evidence of County leadership to promote recovery and resiliency. |
| County Executive Management | 78.5 | Other: Significant onsite review findings related to Standard 78. |
| BH-MCO Executive Management | 86.1 | Updated BH-MCO table of organization – evidence of sufficient staff. |
| BH-MCO Executive Management | 86.2 | OMHSAS onsite review is conducted every 3 years |
| BH-MCO Executive Management | 86.3 | Other: Significant onsite review findings related to Standard 86 |

SMART: Systematic Monitoring, Access, and Retrieval Technology; OMHSAS: Office of Mental Health and Substance Abuse Services; BH-MCO: behavioral health managed care organization; C/FST: Consumer/Family Satisfaction Team.

# Appendix C: OMHSAS-Specific SMART Substandards for MBH Primary Counties

OMHSAS-specific substandards are not required to fulfill BBA requirements. In RY 2022, 31 OMHSAS-specific substandards were evaluated for MBH and its Primary Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in 2022, along with the relevant categories.

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

| Category (SMART Standard) | Evaluated SMART Substandards[1] | | SMART Substandards Under Active Review[2] | | |
|---|---|---|---|---|---|
| | Total | NR | RY 2022 | RY 2021 | RY 2020 |
| Care Management | | | | | |
| Care Management (CM) Staffing | 7 | - | 7 | 0 | 0 |
| Longitudinal CM (and CM Record Review) | 1 | - | 1 | 0 | 0 |
| Complaints and Grievances | | | | | |
| Complaints | 5 | - | 5 | 0 | 0 |
| Grievances | 5 | - | 5 | 0 | 0 |
| Denial | | | | | |
| Denials | 1 | - | 1 | 0 | 0 |
| Executive Management | | | | | |
| County Executive Management | 5 | - | 5 | 0 | 0 |
| BH-MCO Executive Management | 3 | - | 3 | 0 | 0 |
| Enrollee Satisfaction | | | | | |
| Consumer/Family Satisfaction | 3 | - | 0 | 0 | 3 |
| Education and Prevention Programs | | | | | |
| Education and Prevention Programs | 1 | - | 0 | 0 | 1 |
| Total | 31 | - | 27 | 0 | 4 |

[1] The total number of OMHSAS-specific substandards required for the evaluation of Primary Contractor/BH-MCO compliance with OMHSAS standards. Any SMART substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/BH-MCO.

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

OMHSAS: Office of Mental Health & Substance Abuse Services; MBH: Magellan Behavioral Health; SMART: Systematic Monitoring, Access, and Retrieval Technology; NR: Substandards not reviewed; RY: review year; BH-MCO: behavioral health managed care organization.

## Format

This document groups the monitoring standards under the subject headings Care Management, Complaints and Grievances, Denials, Executive Management, Enrollee Satisfaction, and Education and Prevention Programs. The status of each substandard is presented as it appears in the SMART Review Application (i.e., compliant, partially compliant, non-compliant) 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 Primary Contractor/BH-MCO's compliance with selected ongoing OMHSAS-specific monitoring standards.

## Findings

### Care Management

The OMHSAS-specific SMART substandards relating to Care Management are MCO-specific review standards. Eight substandards crosswalk to this category, and MBH and its Primary Contractors were compliant with five substandards, partially compliant with two substandards, non-compliant with one substandard. The status for these substandards is presented in **Table C.2**.

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

| Category | SMART Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Compliant | Partially Compliant | Non-compliant |
| Care Management | | | | | |
| Care Management (CM) Staffing | Substandard 27.1 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 27.2 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 27.3 | 2022 | - | - | All MBH Primary Contractors |
| | Substandard 27.4 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 27.5 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 27.6 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 27.7 | 2022 | - | All MBH Primary Contractors | - |
| Longitudinal CM (and CM Record Review) | Substandard 28.3 | 2022 | - | All MBH Primary Contractors | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year; MBH: Magellan Behavioral Health.

MBH and its Primary Contractors were non-compliant with Substandard 3 of SMART Standard 27 (RY 2022).

**Standard 27:** Care management staffing is sufficient to meet member needs. Appropriate supervisory staff, including access to senior clinicians (peer reviewers, physicians, etc.) is evident.

**Substandard 3:** BH-MCO care management staff represents specialty area of mental health, drug and alcohol, child and adult, and experience in the field.

MBH and its Primary Contractors were partially compliant with Substandard 7 of SMART Standard 27 (RY 2022).

**Standard 27:** See Standard description and determination of compliance under Care Management (CM) Staffing.

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

MBH and its Primary Contractors were partially compliant with Substandard 3 of SMART Standard 28 (RY 2022).

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

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

## Complaints and Grievances

The OMHSAS-specific SMART 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 was compliant with one substandard, partially compliant with three substandards, and non-compliant with six substandards, as indicated in **Table C.3.**

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

| Category | SMART Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Compliant | Partially Compliant | Non-compliant |
| Complaints and Grievances | | | | | |
| Complaints | Substandard 68.1.1 | 2022 | - | - | All MBH Primary Contractors |
| | Substandard 68.1.2 | 2022 | - | - | All MBH Primary Contractors |
| | Substandard 68.5 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 68.6 | 2022 | - | - | All MBH Primary Contractors |
| | Substandard 68.8 | 2022 | - | All MBH Primary Contractors | - |
| Grievances | Substandard 71.1.1 | 2022 | - | - | All MBH Primary Contractors |
| | Substandard 71.1.2 | 2022 | - | - | All MBH Primary Contractors |
| | Substandard 71.5 | 2022 | - | All MBH Primary Contractors | - |
| | Substandard 71.6 | 2022 | - | - | All MBH Primary Contractors |
| | Substandard 71.8 | 2022 | - | All MBH Primary Contractors | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year; MBH: Magellan Behavioral Health.

MBH was non-compliant with Substandards 1 and 2 within SMART Standard 68.1 (RY 2022).

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

**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 non-compliant with Substandard 6 within SMART Standard 68 (RY 2022).

**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 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 (facilitator documents participant's virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent.

MBH was partially compliant with Substandard 8 within SMART Standard 68 (RY 2022).

**Standard 68:** See Standard description and determination of compliance under Complaints.

**Substandard 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.

MBH was non-compliant with Substandards 1 and 2 within SMART Standard 71.1 (RY 2022).

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

**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 demonstrate 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.

MBH was partially compliant with Substandards 5 and 8 within SMART Standard 71 (RY 2022).

**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 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 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.

MBH was non-compliant with Substandard 6 within SMART Standard 71 (RY 2022).

**Standard 71:** See Standard description and determination of compliance under Grievances.

**Substandard 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 (facilitator documents participant's virtual attendance if they are not present to sign) and acknowledgement of the confidentiality requirement. Member consent is documented on the sign-in sheet or elsewhere in the complaint case record for participants that require member consent.

## Denials

The OMHSAS-specific SMART substandard relating to Denials is an MCO-specific review standard. 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 | SMART Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Compliant | Partially Compliant | Non-compliant |
| Denials | | | | | |
| Denials | Substandard 72.3 | 2022 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year; MBH: Magellan Behavioral Health.

## Executive Management

There are eight OMHSAS-specific SMART substandards relating to Executive Management. MBH and its Primary Contractors were compliant with two substandards and partially compliant for three substandards in County Executive Management. MBH and all its Primary Contractors were compliant with all three substandards in BH-MCO Executive Management. The status for these substandards is presented in **Table C.5**.

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

| Category | SMART Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Compliant | Partially Compliant | Non-compliant |
| Executive Management | | | | | |
| County Executive Management | Substandard 78.1 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 78.2 | 2022 | Bucks County, Cambria County, Montgomery County, Northampton County | Lehigh County | - |
| | Substandard 78.3 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 78.4 | 2022 | Bucks County, Cambria County, Montgomery County, Northampton County | Lehigh County | - |
| | Substandard 78.5 | 2022 | Bucks County, Lehigh County, Montgomery County | Cambria County, Northampton County | - |
| BH-MCO Executive Management | Substandard 86.1 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 86.2 | 2022 | All MBH Primary Contractors | - | - |
| | Substandard 86.3 | 2022 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year; MBH: Magellan Behavioral Health.

MBH was partially compliant with Substandards 2, 4, and 5 within SMART Standard 78 (RY 2022).

**Standard 78:** Evidence exists of the County's oversight of functions and activities delegated to the BH-MCO.
- **Substandard 2:** 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.
- **Substandard 4:** There is evidence of County leadership to promote recovery and resiliency.
- **Substandard 5:** Other: Significant onsite review findings related to Standard 78.

## Enrollee Satisfaction

The OMHSAS-specific SMART substandards relating to Enrollee Satisfaction are county-specific review standards. MBH and its Primary Contractors were compliant on all three substandards. The status by Primary Contractor for these is presented in **Table C.6**.

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

| Category | SMART Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Compliant | Partially Compliant | Non-compliant |
| 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; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year; MBH: Magellan Behavioral Health.

## Education and Prevention Programs

The OMHSAS-specific SMART substandard relating to Education and Prevention Programs is MCO-specific. MBH and its Primary Contractors were compliant on the substandard. The status by Primary Contractor is presented in **Table C.7**.

Table C.7: OMHSAS-Specific Requirements Relating to Education and Prevention Programs

| Category | SMART Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Compliant | Partially Compliant | Non-compliant |
| Education and Prevention Programs | | | | | |
| Education and Prevention Programs | Substandard 59.1 | 2020 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; SMART: Systematic Monitoring, Access, and Retrieval Technology; RY: review year; MBH: Magellan Behavioral Health.