pennsylvania

DEPARTMENT OF HUMAN SERVICES

Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy

December 2020

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Glossary of Acronyms

ACAP Adult Community Autism Program

BH Behavioral Health

CAAC County Administrators Advisory Committee

CAHPS® Consumer Assessment of Healthcare Providers & Systems

CAP Corrective Action Plan

CBCM Community-Based Care Management

CHC Community HealthChoices

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

COE Center of Excellence

CPOP CHIP Program Oversight Portal

DHS Department of Human Services

ED Emergency Department

EHR Electronic Health Record

EPSDT Early Periodic Screening, Diagnosis & Treatment

EQR External Quality Review

EQRO External Quality Review Organization

FED Functional Eligibility Determination

FFS Fee-For-Service

HIE Health Information Exchange

HCBS Home and Community-Based Services

HEDIS® Healthcare Effectiveness Data and Information Set

ICF Intermediate Care Facility

ICP Integrated Care Plan

IEB Independent Enrollment Broker

IGA Inter-Governmental Affairs

IPRO Island Peer Review Organization

ISAC Information Sharing & Advisory Committee

KAS Keystone Autism Services

LCD Level of Care Determination

LIFE Living Independence for the Elderly

MA Medical Assistance

MAAC Medical Assistance Advisory Committee

MATP Medical Assistance Transportation Program

MCO Managed Care Organization

MCQS Managed Care Quality Strategy

MHSIP Mental Health Statistics Improvement Program

MLTSS Medicaid Long Term Services & Supports

MPOP Medicaid Program Oversight Portal

NCQA National Committee for Quality Assurance

NQF National Quality Forum

ODP Office of Developmental Programs

OLTL Office of Long-Term Living

OMAP Office of Medical Assistance Programs

OMHSAS Office of Mental Health & Substance Abuse Services

OUD Opioid Use Disorder

P3N Pennsylvania Patient & Provider Network

P4P Pay for Performance

PACE Program for All-inclusive Care for the Elderly

PAPM Pennsylvania Performance Measures

PDL Preferred Drug List

PEPS Program Evaluation Performance Summary

PH Physical Health

PIHP Prepaid Inpatient Health Plan

PIP Performance Improvement Project

P&T Pharmacy and Therapeutics

QQRM Quarterly Quality Review Meeting

SDOH Social Determinants of Health

SMART Systemic Monitoring and Access Retrieval Technology

SPMI Serious Persistent Mental Illness

SUD Substance Use Disorder

VBP Value Based Payment

Introduction

Purpose

The Medical Assistance (MA) and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy (MCQS) for Pennsylvania is required by the Centers for Medicare & Medicaid Services (CMS) in the regulation at 42 CFR § 438.340 to ensure the access to high quality health care by the managed care organizations contracted by the Pennsylvania Department of Human Services (DHS). It is not intended to describe all the activities that DHS undertakes to assure the quality of care rendered to Pennsylvania Medicaid beneficiaries and CHIP enrollees.

Scope

DHS is committed to ensuring Pennsylvanians enrolled in Medicaid, also referred to as Medical Assistance or MA throughout, and the CHIP managed care programs receive high quality services. Pennsylvania currently operates a statewide, fully capitated Medicaid managed care program, called the HealthChoices program, that includes five behavioral health managed care organizations (BH-MCOs) and nine physical health managed care organizations (PH-MCOs) operating under the CMS-approved 1915(b) waiver authority. In 2009, DHS obtained approval for a Prepaid Inpatient Health Plan (PIHP) under the 1915(a) authority to create the Adult Community Autism Program (ACAP) in four counties. Most recently, in 2018, DHS implemented its managed long-term services and supports (MLTSS) program, Community HealthChoices (CHC) for low-income older adults and adults with physical disabilities. CHC provides physical health and MLTSS through a CMS approved concurrent 1915(b) and 1915(c) waiver authority. This enhanced the already established managed care system for the Living Independence for the Elderly (LIFE) program (known nationally as PACE, the Program for All-Inclusive Care for the Elderly), and the state-funded Act 150 Attendant Care program. Ninety-seven percent (97%) of the over 2.9 million individuals in Pennsylvania's Medicaid program are enrolled in a managed care program. This MCQS will describe the initiatives required to comply with 42 CFR § 438.330 for each of these programs, as well as CHIP.

Quality Management Structure

Leadership

DHS is comprised of several offices, each responsible for administering a variety of programs. Relevant here are six offices: the Office of Medical Assistance Programs (OMAP), the Office of Mental Health and Substance Abuse Services (OMHSAS), the Office of Long-Term Living (OLTL), the Office of Developmental Programs (ODP), the Office of PeopleStat, and the Office of Inter-Governmental Affairs (IGA) (See Figure 1). Each of these offices is led by a Deputy Secretary or a Director who reports directly to the Secretary of DHS.

OMAP administers the mandatory, full-risk managed care PH HealthChoices program that works with PH-MCOs to deliver physical healthcare services to MA enrollees. In 2019, OMAP also became responsible for administration of CHIP. Previously, CHIP was a standalone office. The Office of CHIP was integrated into OMAP to better align programmatic and operational standards between the CHIP and HealthChoices programs. Oversight of the PH-MCOs is performed by the Bureau of Managed Care Operations, which includes the Division of Quality and Special Needs Coordination, which oversees the quality functions of the PH-MCOs. Oversight of the CHIP MCOs is performed within the Office of CHIP by the Divisions of Operations, Policy, and Quality.

OMHSAS administers the Behavioral HealthChoices program through agreements with county-based Primary Contractors, who contract with BH-MCOs, and in some counties through direct agreements with BH-MCOs, for the provision of behavioral healthcare services to MA enrollees. Oversight of the Primary Contractors and BH-MCOs is the responsibility of the Bureau of Community Hospital Operations. OMHSAS also has a Bureau of Quality Management and Data Review that supports that oversight function.

OLTL administers CHC. CHC provides physical healthcare and long-term services and supports (LTSS) for individuals who are over age 21 and are either (1) dually enrolled in or eligible for Medicaid and Medicare or (2) both Medicaid financially eligible and nursing facility clinically eligible. OLTL's Bureau of Coordinated

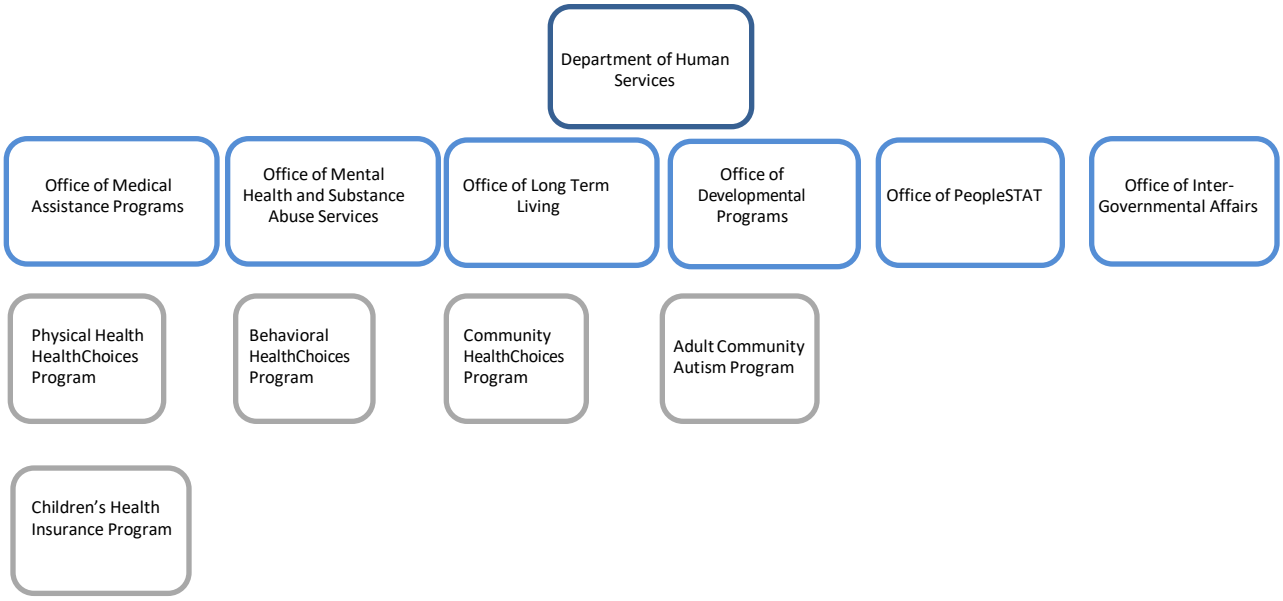
and Integrated Services and Bureau of Quality Assurance and Program Analytics oversees the CHC-MCOs to ensure quality and compliance.

ODP provides oversight of the ACAP, which was designed as an integrated service delivery system to provide physical, behavioral, and community-based services to adults with autism. As an integrated delivery system, Keystone Autism Services (KAS) serves as both service provider and MCO. ODP's Bureau of Supports for Autism and Special Populations is responsible for overseeing ACAP's administration by KAS.

On a weekly basis, DHS executive leadership and representatives of each program office attend a meeting hosted by the PeopleStat Office. PeopleStat is modeled after the CompStat program developed by the New York City Police Department in the 1990s to use data surveillance and analytics to inform program interventions. Each meeting allows DHS staff to review recent metrics that shed light on the operations of DHS programs and to measure achievements of specified goals and objectives. The PeopleStat framework is a critical component of quality assurance and promotes intentional, targeted interventions as well as identification of department- or program-wide trends.

In 2019, DHS created an Office of IGA, which is responsible for coordinating DHS's work with external stakeholders through boards, commissions, councils, advisory committees, work groups, task forces, and the like. Several external stakeholder groups help to inform and guide DHS in its administration of managed care programs. Each of the relevant stakeholder groups is described later in this strategy.

Figure 1. DHS Organizational Chart



DHS's Guiding Principles and Strategic Plan

Each of the five managed care programs are united by a shared mission, vision, and set of core values. The goals and objectives of each program are synthesized in a single Strategic Plan for DHS. The goals and objectives highlighted below represent the portions of the Strategic Plan that are directly relevant to the MCQS. These goals and objectives reflect Pennsylvania's commitment to providing high quality health care to the individuals served by Medicaid and CHIP managed care programs.

Mission

Our mission is to assist Pennsylvanians in achieving safe, healthy, and productive lives while being an accountable steward of commonwealth resources.

Vision

DHS is committed to making sure all Pennsylvanians have access to high-quality services and serving more people in the community.

Values

1. **Collaboration**: We coordinate our practices internally and externally with our employees and stakeholders.
2. **Communication**: We strive to be transparent and open in our conversations, both written and oral. We will promote awareness with our employees and stakeholders.
3. **Accountability**: We are responsible caretakers of taxpayer funds entrusted to DHS by engaging in sound financial management practices when providing services and supports. We are responsible for our actions and we will hold our partners to similar standards in providing services and supports to our stakeholder community.
4. **Respect**: We foster a fair, open and honest work environment. We embrace our stakeholders and treat others as we want to be treated.
5. **Effectiveness**: We are efficient in our operations and empower our employees to deliver results for our stakeholders.

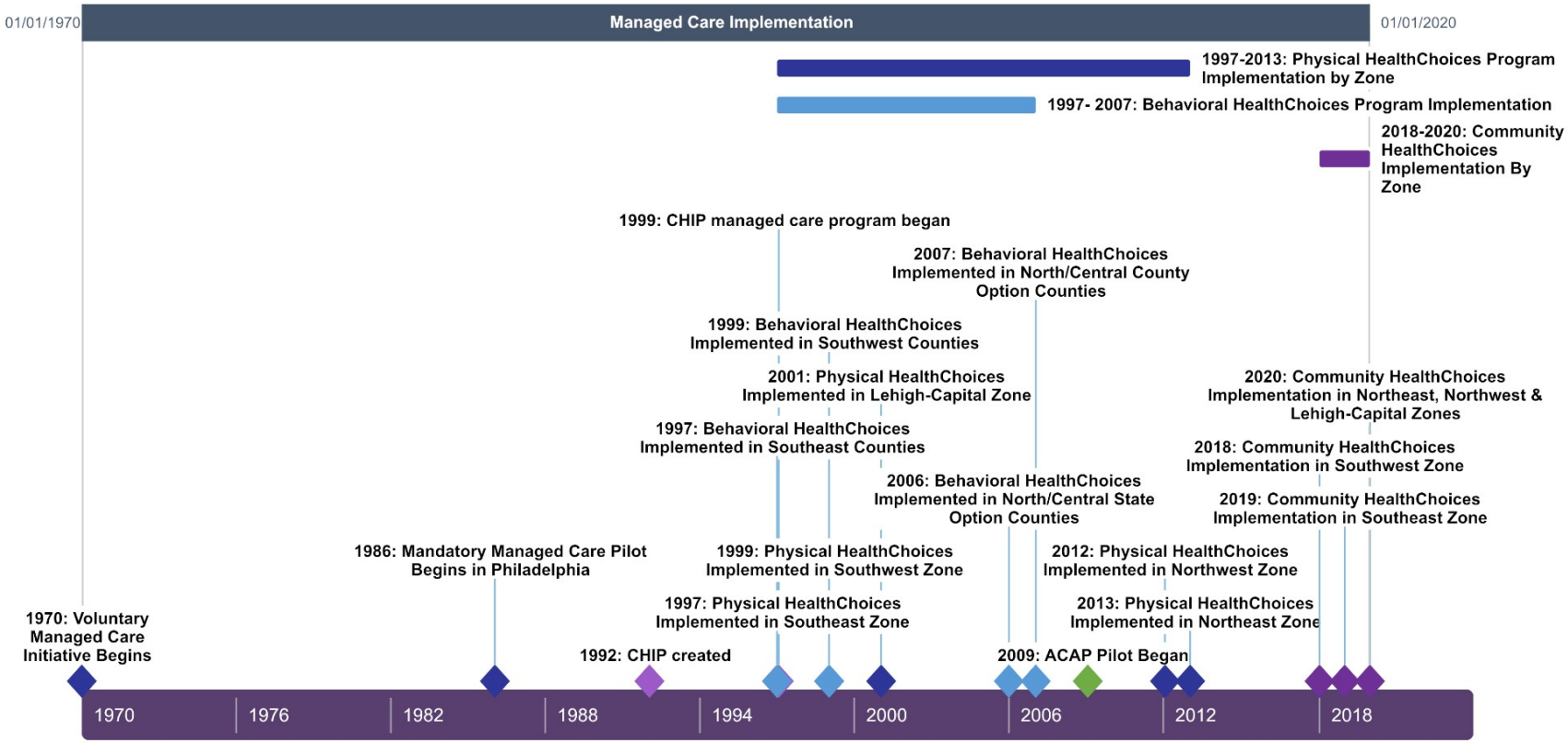
Overview of Medicaid and CHIP Managed Care in Pennsylvania

For several decades, Pennsylvania has been a leader of health care delivery reform. Pennsylvania has provided some form of managed care to the MA population since the 1970s. Today, Pennsylvania administers five separate managed care programs: Physical HealthChoices, Behavioral HealthChoices, Community HealthChoices, ACAP, and CHIP. Figure 2 depicts a timeline of managed care implementation in Medicaid and CHIP in Pennsylvania, beginning in 1970 and ending in 2020. Pennsylvania used a phased-in approach to adopt statewide mandatory managed care in the Physical HealthChoices, Behavioral HealthChoices, and CHC. Each of these programs operate in five zones as shown on the map in Figure 3.

The use of zones to phase in the statewide mandatory managed care program allowed enough time and resources to successfully complete operational and readiness reviews for implementation in a systematic fashion throughout the state. As the programs were implemented by zone, lessons learned from each implementation helped to ease the transition in subsequent zones. The use of the zone structure allows MCOs to develop offerings that are targeted to the population of an area in order to account for demographic differences. The order of implementation was determined based on the existing penetration of managed care within the delivery systems, which was used as a proxy for readiness. Using zones allows for consistency across the three HealthChoices programs.

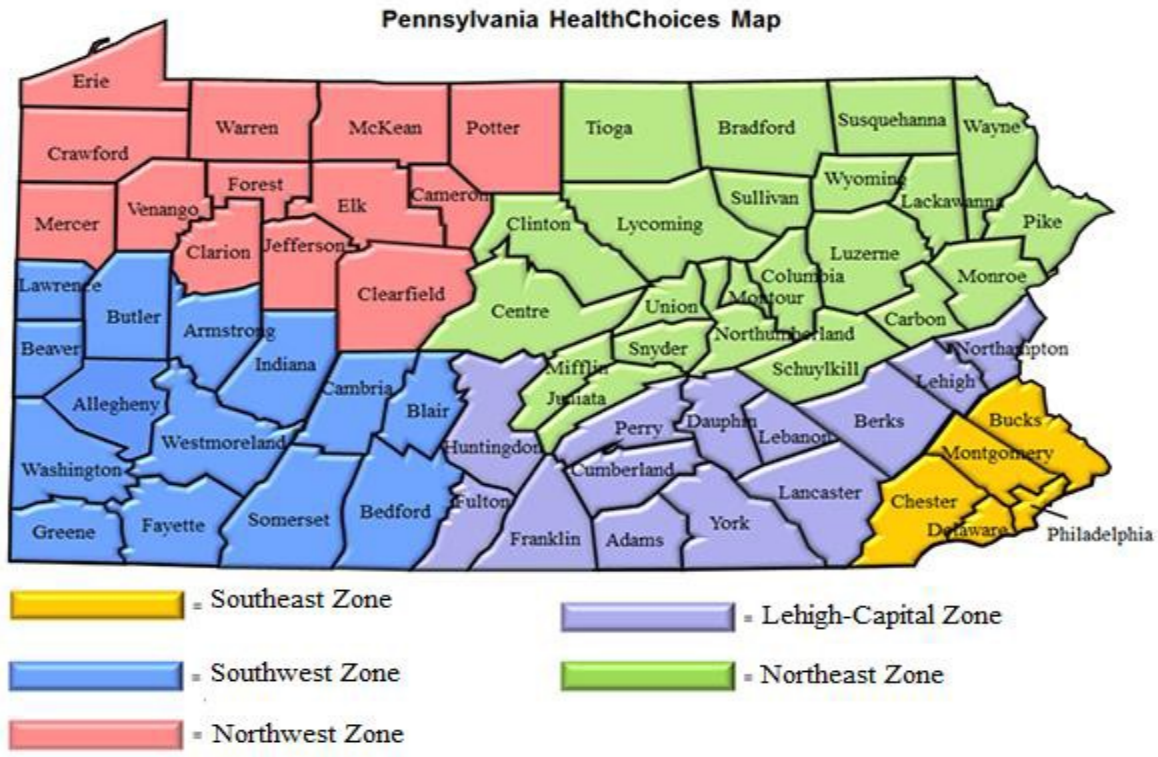
Zones are currently not used in the remaining managed care programs administered by DHS, CHIP, and ACAP. As CHIP integrates into DHS and seeks to re-procure managed care services in the future, the program will review the benefits of a zoned system and will analyze whether this would be a valuable operational change for the CHIP program. The ACAP oversees a small managed care program in a few counties, so zones are not applicable to this program.

Figure 2. Managed Care Implementation Timeline in Pennsylvania



Zonal analyses are used to determine regional effects in cost, quality performance measure results, demographics, penetration of services, identification of disparities in performance between MCOs and within each MCO across different regions. While, like OMAP and OLTL, OMHSAS collects data by zone, OMHSAS primarily analyzes quality data at the Primary Contractor and BH-MCO levels because those are the levels at which the Behavioral Health HealthChoices program is more likely to experience variance. As DHS's quality programming and data analyses grow across each respective managed care program, more zonal analyses will be added to behavioral health quality reporting, and integration of joint performance results between MCOs across different program offices will take place. This integrated performance analysis is just beginning and will increase over the next three years as integrated data will become more available to the entire Medicaid managed care system.

Figure 3. Map of Pennsylvania's Managed Care Zones.



Physical HealthChoices is Pennsylvania's mandatory Medicaid managed care program, which covers medical and surgical services as well as prescriptions for eligible individuals. This program covers the benefits found in the table found on pages 26-28 of the HealthChoices Member Handbook Template, available at http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_276605.pdf.

As a behavioral health carve-out state, Pennsylvania provides coverage of behavioral health services to MA enrollees through a separate managed care program called Behavioral HealthChoices. Behavioral HealthChoices covers the adult benefit services listed under Section 7 found in the following link: http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_276605.pdf. In addition to the services for adults, Behavioral HealthChoices covers the benefits outlined in the state plan services for children as well as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) preventive behavioral health care services for children under age 21 if deemed medically necessary. Because of the broad array of community-based mental health and drug and alcohol services that are administered and coordinated

by local county governments pursuant to Pennsylvania law, including the Mental Health and Intellectual Disability Act of 1966, as the Behavioral HealthChoices program rolled out, county governments were given the "right of first opportunity." Today, the Behavioral HealthChoices program continues to consist of many direct agreements with local county governments that manage the program. In most cases, these counties, either individually or through joinder agreements, enter into a subcontract with a BH-MCO and delegate much of the overall administration of the Behavioral HealthChoices benefits to the BH-MCO. Twenty-four counties have waived their right of first opportunity. OMHSAS enters into agreements directly with a BH-MCO to administer the Behavioral HealthChoices program in these counties.

CHC is Pennsylvania's managed care program that covers physical health and long-term services and supports, for Medicaid-eligible individuals who are either dually eligible for Medicaid and Medicare or who are also nursing facility clinically eligible. Behavioral HealthChoices provides the BH services needed by Community HealthChoices participants. A list of covered services under Community HealthChoices is accessible at http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_264102.pdf. CHC is Pennsylvania's newest managed care program and represents the most recent wave of delivery system reform in the Commonwealth.

Each individual enrolled in MA in Pennsylvania is enrolled in both a Physical HealthChoices or Community HealthChoices MCO and a Behavioral HealthChoices MCO, except for a small number of individuals who are enrolled in the Fee-For-Service (FFS) Program. In each county there is only one BH-MCO, while there are multiple PH-MCOs and CHC-MCOs operating in each county.

Once a beneficiary is determined eligible for MA, they are entered into the MA FFS Program on their date of eligibility. Depending upon their date of eligibility, a beneficiary can be enrolled in the FFS Program for three to six weeks. During this time, the DHS's Enrollment Assistance Contractor independently and proactively assists the beneficiaries with a voluntary selection of a PH MCO and a Primary Care Physician (PCP) from the MCO's network. During their brief period of enrollment in the FFS program, beneficiaries can utilize any MA enrolled providers for services. Once they are enrolled in an MCO, they use their selected PCP and MCO network facilities and provider types. The procedures for ensuring continuity of services are designed to ensure the safe transition and continuity of care for MA recipients who are under a clinically appropriate course of treatment for a medical and/or behavioral health condition when they transfer from the MA FFS program to an MCO, between MCOs, and from an MCO to FFS. These procedures address: 1. continuity of prior authorized services for adults; 2. continuity of "clinically appropriate course of treatment" plans for children and adults. These procedures are captured in MA Bulletin 99-03-13, available at https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/d_004020.pdf.

This process differs slightly for individuals enrolled in a Home and Community Based Services (HCBS) waiver program as they transition to enrollment in a CHC-MCO. CHC-MCOs are required to maintain continuity of services for Participants transitioning into CHC from other HCBS programs so that they do not experience an interruption or gap of services as they move to CHC. To ensure continuity of services, CHC-MCOs must obtain the current Person-Centered Service Plans of transitioning participants. When a CHC-MCO receives a transitioning participant from another HCBS program, the MCO receives information about the HCBS program from which the participant is transitioning as well as the individual's service plan.

In 1992, Pennsylvania created the CHIP program, which went on to serve as the model for the federal CHIP program, codified in Title 21 of the Social Security Act. CHIP provides coverage for physical and behavioral health services as well as prescriptions to children under 19 years of age in Pennsylvania. Any child under 19 years of age is eligible to enroll in CHIP regardless of household income; however, cost-sharing levels vary. A complete list of covered services may be found in Part 2 of the CHIP Eligibility and Benefits Handbook, located at https://www.chipcoverspakids.com/Eligibility/Documents/CHIP%20Eligibility%20and%20Benefits%20Handbook%202017.pdf. CHIP moved from the Pennsylvania Insurance Department to DHS effective with a change in state law on December 20, 2015. In 2020, nearly 186,000 children are enrolled in CHIP MCOs.

ACAP covers physical health, behavioral health, social, recreational, transportation, employment, therapeutic, educational, crisis, in-home support, and independent living services for individuals with autism

who are enrolled in MA in four counties in Central Pennsylvania. For a description of the services provided by ACAP, see https://www.dhs.pa.gov/Services/Disabilities-Aging/Documents/ACAP/ACAP-Service%20Descriptions.pdf. DHS obtained approval in August of 2009 for a PIHP under the 1915(a) authority to create the ACAP and serves up to 200 individuals in the program. ACAP was the first program in the nation to use a single HCBS provider, KAS, to provide an integrated system of care as a traditional managed care organization. ACAP was designed as an integrated service delivery system to provide physical, behavioral, and community-based services to adults with autism. Participants in ACAP are adults 21 years of age or older, financially eligible for MA, possessing a diagnosis of autism, and certified as meeting Medicaid program clinical eligibility for an Intermediate Care Facility (ICF). KAS, a subsidiary of Keystone Human Services, functions as the service provider as well as the MCO. ACAP serves participants in Cumberland, Dauphin, Chester, and Lancaster Counties in Pennsylvania.

Delivery System Reform

On January 1, 2018, DHS began a phased-in implementation of the CHC program, starting in the Southwest zone. On January 1, 2019, CHC was implemented in the Southeast zone. On January 1, 2020, all remaining zones implemented CHC. This new program represents a major delivery system reform as the healthcare and long-term services and supports for eligible individuals has transitioned from a FFS model to a managed care model. This change in service delivery has been accomplished through a concurrent 1915(b) and 1915(c) HCBS waiver.

For individuals who seek MA coverage for LTSS, the eligibility process for individuals seeking LTSS under CHC is facilitated by an Independent Enrollment Broker (IEB). The CHC LTSS eligibility process has a financial eligibility component and a clinical eligibility component. The county assistance offices process the determination of financial eligibility for benefits. In regard to the clinical eligibility, when the applicant first applies for CHC LTSS, the IEB makes a referral to the assessment entity for a level of care determination (LCD). In Pennsylvania, the LCD tool is called the functional eligibility determination (FED) tool. OLTL applies the FED, in addition to a physician certification, for the clinical eligibility portion of determining Medicaid eligibility within its LTSS programs.

The FED was derived from the well-established interRAI® suite of tools, and items were directly taken from the interRAI® Home Care Assessment System. interRAI® is an international collaborative to improve the quality of life of vulnerable persons through a seamless comprehensive assessment system. The interRAI® HC was designed to be a user-friendly, reliable, person-centered system that informs and guides comprehensive planning of care and services in community-based settings. The interRAI® Home Care Assessment focuses on the person's functioning and quality of life by assessing needs, strengthens, and preferences. Pennsylvania selected the interRAI® Home Care tool because it provides the basis for an outcome-based assessment of the person's response to care or services. DHS requires all CHC-MCOs to use the interRAI® Home Care Assessment to help start the development of the comprehensive needs assessments for participants. Both the FED and the interRAI® Home Care information is electronically submitted into a centralized system to populate areas of needs for individuals. A Service Coordination entity is also required to schedule a visit and meet with the participant and completes the remainder of the interRAI® Home Care survey. This needs assessment is the basis for developing the participants' Individualized Service Plan.

OLTL has designed an approach in oversight and monitoring of the CHC program as described throughout this document. This ensures quality assurance that will help identify system improvements for CHC, including readiness review, early implementation and ongoing monitoring. Using both the early launch and steady state approach allows DHS to coordinate its approach in each cycle impacting the CHC program implementation. This also helps ensure CHC-MCOs are ready to provide services, identify unanticipated implementation challenges and address them in real time, and conduct annual monitoring of plans. An enhancement to CHC is the seven-year independent evaluation that is being conducted by the University of Pittsburgh's Health Policy Institute, Medicaid Research Center (please see http://www.healthchoices.pa.gov/info/resources/publications/community/evaluation-plan/index.htm).

Development and Review of Managed Care Quality Strategy

DHS sought input on this MCQS from its advisory committees described below, as well as from members of the public through a solicitation for public comment during a 30-day comment period announced by a

Public Notice. The MCQS is posted on DHS's website and will be updated as needed. DHS views this MCQS as a dynamic document that needs to be assessed for effectiveness as each of the programs described above develop and change over the course of time. Ongoing review of the MCQS is necessary because of rapid time quality improvement techniques and the leverage of more real time quality measurement through health information exchange. This MCQS will be updated and re-submitted to CMS every three calendar years or whenever federal or state statutory changes necessitate that changes be made to the MCQS.

Stakeholders

DHS engages with several stakeholder groups that act in an advisory capacity related to its managed care programs.

Medical Assistance Advisory Committee (MAAC) - As set forth in the Committee's operating guidelines, the mission of the MAAC is to provide DHS with advice about access to and delivery of quality health care services in an efficient, economical, and responsive manner to low income individuals and families. The MAAC has several subcommittees: The Consumer Subcommittee, which advises DHS on key initiatives and issues related to the provision of services in medical assistance programs from a participant or consumer perspective; the Medicaid Long Term Services and Supports Subcommittee, which advises DHS on key initiatives and issues related to the Community HealthChoices program; and the Managed Care Delivery System Subcommittee, which serves as a forum for physical and behavioral managed care organizations and advocates to advise about the delivery of health care service to the consumers who receive their health care through the managed care organizations.

County Administrators Advisory Committee (CAAC) - Pennsylvania Association of County Administrators of Mental Health and Developmental Services represents the mental health and intellectual disability program administrative entities from all of Pennsylvania's counties. They make recommendations to establish improvements in the county systems of care for mental health and developmental services. The CAAC also has a HealthChoices Subcommittee, which is focused exclusively on issues pertaining to Pennsylvania's behavioral health managed care program.

Pennsylvania Mental Health Planning Council - This council consists of three committees and two sub-committees: Children's Advisory Committee, Adult Advisory Committee, Older Adult Advisory Committee, Transition Youth Sub-Committee and Persons in Recovery Sub-Committee. The committees have a broad mandate to advise OMHSAS and DHS on issues impacting mental health, substance abuse, behavioral health disorders and cross-system disability.

Children's Health Advisory Council - The council is tasked with reviewing outreach activities and may make recommendations to DHS. In addition, the council reviews and evaluates the accessibility and availability of services delivered to children enrolled in the CHIP program.

Information Sharing and Advisory Committee (ISAC) - ISAC is ODP's quality and advisory council. ODP engages stakeholders through the ISAC. ISAC members include individuals with an intellectual disability and/or autism, families, representatives from each of the state associations committed to supporting individuals with an intellectual disability and/or autism, advocates, county government, providers, supports coordination agencies, the Developmental Disabilities Council, Disability Rights Pennsylvania and the Temple University Institute on Disabilities.

Managed Care Goals and Objectives

The following goals and their associated objectives align with the mission, vision and values of DHS. Each Medicaid managed care program has unique specific goals and objectives, but they all relate back to DHS's overarching priorities:

1. Increase access to healthcare services
2. Improve quality of healthcare services
3. Bend the healthcare cost curve

For a table detailing the specific objectives related to each of these goals for each managed care program, please refer to Appendix A.

Increase Access to Healthcare Services

Network Adequacy

Each managed care program agreement entered into by DHS identifies network adequacy standards for those programs. These standards are consistent with state regulations and must also comply with CMS network adequacy standards as outlined in 42 CFR § 438.68(b)(1)(viii) and 438.68(b)(3). Each program must ensure that its provider network is adequate to provide its members with access to quality care through participating professionals, in a timely manner, and without the need to travel excessive distances. Typical oversight and monitoring of provider networks include review of geographic access maps using member level data detailing the number, location and specialties of the provider networks. Some program offices have developed web-based tools that are updated weekly with managed care provider data for more in-depth monitoring of the provider networks. Refer to Appendix C for specific network adequacy standards.

Medicaid Program Oversight Portal (MPOP) and CHIP Program Oversight Portal (CPOP)

MPOP is an innovative cloud-based platform that provides easy access to a range of operational and analytical solutions, specifically channeled towards oversight of the Medicaid program, MCO operations, and provider network compliance. It includes dashboards for Access to Care, Provider Network Submissions, Provider Negotiations and Terminations, Provider Network Adequacy, Systemic Monitoring and Access Retrieval Technology (SMART), and more. CHIP has developed a similar platform, called CPOP, and there are also plans for OLTL to design a similar platform. MPOP is divided into five functional business oversight areas (domains): Population, Contract, Quality, Financial and Provider. Within each domain, there are three levels of application: Operations, Program and Executive. See Table 1 for a summary of application functionality by three of the DHS Offices. Please refer to the Acronyms Glossary at the beginning of this document for abbreviated terms. OMHSAS and ODP do not utilize a program oversight portal such as MPOP or CPOP at this time; their methodologies for ensuring compliance with all contractual standards, including network adequacy, are discussed later in this document.

Table 1: MPOP Applications by DHS Programs

Application	Physical HealthChoices	Community HealthChoices	CHIP
MCO Oversight Dashboard	X	X	X
Network Adequacy	X	X	X
HCBS Network Adequacy		X	
Negotiations and Terminations	X	X	
SMART	X	X	X
MATP	X		
Provider Network Analytics	X	X	X
Access to Care	X	X	
Provider Enrollment Fee-for-Service	X		
Key Performance Measures	X	X	X
Care Management	X		
CAHPS	X	X	X
HEDIS®	X	X	X
Member Level Data	X	X	
FQHC Rate Manager	X		X
Network Geography	X		
Integrated Quality Dashboard	X	X	X
PAPM	X	X	

Credentialing

The HealthChoices and CHIP MCOs and BH Primary Contractors must comply with the credentialing and re-credentialing requirements specified in 42 CFR § 438.214. Each program's agreement with the MCO or BH Primary Contractor includes standards for credentialing and re-credentialing providers. The PH and CHC Agreements also require that the MCOs receive accreditation by a nationally recognized organization, such as the National Committee for Quality Assurance (NCQA). To receive NCQA accreditation, MCOs must follow NCQA's Health Plan Standards and Guidelines credentialing and re-credentialing requirements when initially credentialing and re-credentialing providers. The ACAP Agreement includes a provision that requires the Provider to obtain all required licenses, certifications, credentials, and permits from federal, state, and local authorities.

Uniform Preferred Drug List

In order to ensure consistent access to medications among MCOs, in January 2020, the HealthChoices program implemented a uniform statewide preferred drug list (PDL). The PDL eliminates the need for beneficiaries to have to change medications when they change plans due to differing formularies. In addition, a statewide PDL simplifies prior authorization processes for prescribers. The DHS Pharmacy and Therapeutics (P&T) Committee, which is comprised of external physicians, pharmacists, consumer representatives, DHS Medical Directors, and voting members from each of the MCOs, recommends which therapeutic classes to include on the PDL, preferred or non-preferred status for the drugs in each class, and corresponding prior authorization guidelines for each class. The Committee's recommendations are approved by the Secretary of DHS prior to implementation. The P&T Committee recommends preferred or non-preferred status for drugs on the PDL based on their clinical effectiveness, safety and outcomes. When drugs within a class are clinically equivalent, the Committee considers the comparative cost-effectiveness of all drugs in the class. Drugs designated as non-preferred are available but require prior authorization. MA-covered drugs in therapeutic classes that are not included in the statewide PDL continue to be covered drugs for MA beneficiaries. DHS's Pharmacy and Therapeutics Committee meetings are open to the public.

Standards

Access and Operations

DHS staff monitor compliance with all standards included in the agreements with the MCOs, but certain standards bear mention in this document. For a complete listing of the required components of 42 CFR Part 438, subpart D, as well as identification of where to find reference to these standards in the managed care programs' agreements or other governing documents, please refer to Appendices B-D.

Special Needs

In the PH HealthChoices program, the term "special needs" is defined as follows: "This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions or life circumstance which may serve as a barrier to the member's access to care or services." All pertinent information gathered by the IEB at the time of enrollment is sent to the PH-MCO the member has chosen. The PH-MCO also gathers other data on new members by conducting new member outreach calls. Member education has been one of the basic tenets of the HealthChoices program. PH-MCOs have developed and implemented effective member education and outreach programs that include health education programs focusing on the leading causes of hospitalization and emergency room use, and health initiatives that target members with special needs, including those diagnosed with HIV/AIDS, intellectual disabilities, chronic diseases, etc. PH-MCOs are also required to establish and maintain a Health Education Advisory Committee that includes beneficiaries and providers of the community to advise on the health education needs of HealthChoices members. Representation on this Committee must include, but not be limited to, women, minorities, persons with Special Needs and at least one (1) person with expertise on the medical needs of children with Special Needs. Provider representation includes physical health, behavioral health, and dental health Providers.

In the Behavioral Health HealthChoices program, services are adapted to meet the special needs of people with mental illness who are affected by one or more of such factors as aging, substance abuse,

physical disability, loss of sight/hearing, intellectual disability, homelessness, HIV/AIDS, and involvement in the criminal justice system. Counties are required to have outreach teams identify older citizens and people with special needs who are in need of mental health services. The county continuum of services allows individuals who have special needs to maintain the highest level of independence possible and the county networks with advocacy groups for persons with special needs to identify all resources available for the consumer to maintain the highest level of independence possible. County programs actively seek and utilize input from persons with special needs, their family members and advocates, in the development of county plans. Consumer satisfaction data indicates that input has been sought from consumers with special needs, such as persons who are deaf, hard of hearing, deaf-blind, elderly, or have HIV/AIDS, and that the data indicates that consumers with special needs are treated with respect, dignity, and that they understand service options, and how to access services.

In CHC, healthcare and LTSS are provided to older Pennsylvanians and individuals with physical disabilities in order to help them remain in their homes and communities. Individuals 21 or older and have both Medicare and Medicaid or receive LTSS through Medicaid because they need help with everyday personal tasks, are covered by CHC. CHC coordinates participants' health care coverage to improve the quality of their health care experience — serving more people in communities rather than in facilities, giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life. The process for identifying these individuals is explained in the section of this strategy related to delivery system reform in the area of LTSS.

Race, Ethnicity and Primary Language

PH, BH, CHC, and CHIP MCOs and providers, as well as KAS, are contractually required to demonstrate cultural competency. MCOs and providers must be willing and able to make necessary distinctions between traditional treatment methods and nontraditional treatment methods that may be equally effective and are more consistent with the member's racial, ethnic or cultural background. MCOs and providers must demonstrate consistency in providing quality care across a variety of races, ethnicities, and cultures.

The IEB may identify members who speak a language other than English as their first language and will share this information with the member's MCO. MCOs are responsible for providing, at no cost to members, oral interpretation services in every language necessary to meet the needs of all members, upon request by the member. Additionally, all written materials disseminated must be available in each prevalent language, as determined by DHS. MCOs also include appropriate instructions on all materials about how to obtain assistance with accessing an appropriate provider, how to obtain member materials in an alternate language, and how to access interpreter and translation services. The MCOs post this information on their web sites.

OMHSAS has developed and maintains a Strategic Plan for Cultural Competency, which contains an objective to incorporate cultural competence as a part ongoing improvement processes (http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/s_002546.pdf). This will be accomplished through the following action steps: operationalize the standards and develop performance indicators that OMHSAS leadership require in order to implement cultural competence throughout the BH system of care; collect and disseminate current information and resources regarding cultural competence; develop mechanisms for review and monitoring of the cultural competence strategic plan; and develop an annual report for the review of cultural competence and incorporate findings into the plan for continuous quality improvement.

Improve Quality of Healthcare Services

Oversight of Managed Care Organizations

Monitoring

The HealthChoices and CHIP MCOs are held to standards set by CMS to ensure that all members receive quality and appropriate care. For the standards to be assessed, there are requirements built into the agreements between DHS and the MCOs, as demonstrated in Appendices B-D. DHS personnel oversee these requirements on a regular basis, in part through the use of the MPOP/CPOP tool. Oversight by DHS identifies and resolves discrepancies and/or deficiencies in standards in a timely manner. Each MCO is

monitored for compliance with the terms of its agreement(s) with DHS or DHS's Primary Contractor. These monitoring processes are the primary way in which DHS ensures that quality services are being provided to the individuals served by the MCOs.

DHS staff monitor compliance with all standards included in the agreements with the MCOs, but certain standards bear mention in this document. For a complete listing of the required components of 42 CFR Part 438, subpart D, as well as identification of where to find reference to these standards in the managed care programs' agreements or other governing documents, please refer to Appendices B-D.

DHS collects Healthcare Effectiveness Data and Information Set (HEDIS®) measures on an annual basis from the MCOs as indicated in Appendix F. The MCOs report on all HEDIS® measures required by DHS as well as the Medicaid Adult and Child core sets. The collection of these and the state-specific measures support the Quarterly Quality Review Meetings (QQRMs) that DHS holds with each MCO. The QQRM is an opportunity to:

- Review the MCO performance against stated goals.
- Investigate causes of missed goals and targets.
- Monitor progress of initiatives to improve performance.
- Establish new targets.

DHS implemented a Pay-for-Performance (P4P) program for Physical Health HealthChoices MCOs and providers to encourage continuous quality by aligning incentive payments with high quality health care for all members. The PH-MCOs must submit to DHS annually their proposed Provider P4P program for review and approval. The PH-MCOs also are required to submit an analysis of their Provider P4P program annually to DHS. Similarly, in 2021, OMHSAS is implementing a P4P program that will provide incentive payments to Primary Contractors for meeting quality benchmarks and performance improvement goals.

DHS monitors the day-to-day operations of the HealthChoices and CHIP MCOs regarding provider and member outreach approvals, tracking of stakeholder issues and issue resolution, and staffing and subcontractor monitoring. DHS also monitors and enforces MCO compliance with the MCO agreement to ensure adherence to all federal and state requirements. DHS collaborates with MCOs to identify both significant favorable and unfavorable variances in performance targets, issues, and trends. MCOs must determine the root cause for unfavorable variances and develop Corrective Action Plans (CAPs) to address the issues. DHS enforces the CAPs and any resulting sanctions or offsets. Contract managers oversee a team of DHS staff that includes direct reports who serve as contract monitors and ancillary staff from various other bureaus and program offices who lend their support in the overall oversight of the MCOs. These other staff include individuals who focus on financial, systems, grievance and appeals, special needs, clinical, program integrity, and third-party liability.

On an ongoing basis, DHS staff members who comprise the MCO contract management teams are responsible for monitoring certain agreement standards for each MCO. Program monitors and supporting team members in OMAP, OLTL, and CHIP use an electronic tool known as SMART to conduct this monitoring of multiple performance standards. SMART is a menu-driven database that stores documentation of agreement compliance monitoring results. Depending upon the nature and priority of the standard, the contract manager reviews the standards on a monthly, quarterly, semi-annual, or annual basis. The reviewer assigns a rating of "compliant" or "non-compliant" for each of these standards. For noncompliant standards, the contract manager and their program monitors may discuss with the MCO a solution to address the agreement non-compliance or area needing improvement. The MCO then has an opportunity to implement a solution to the noncompliant issue. If the deficiency or non-compliant issue cannot be resolved via this process, the MCO may be required to present a CAP. DHS contract manager tracks and monitors the MCO's adherence to this CAP until the problem is resolved. In addition to MPOP and CPOP, DHS also uses a monitoring instrument called the Program Evaluation Performance Summary (PEPS). One hundred and seventy-two PEPS standards are reviewed quarterly to determine compliance with federal and state requirements over a rolling three-year period. The compliance determination is at the Primary Contractor or the MCO level. The goal is for each standard to be designated as "met," as opposed to "partially met" or "not met." Operationally, DHS reviewers often use the "partially met" designation to encourage the Primary Contractor/MCO in the improvement of their processes to improve the reviewed PEPS Standard. A discussion of the finding with the Primary Contractor or the MCO usually follows this

use of the "partially met" result. If a standard is "not met," a CAP is developed. DHS may also determine that a CAP is necessary if a standard is "partially met."

As part of monitoring the MCOs' compliance with their agreement, DHS conducts on-site visits and holds QQRMs with each individual MCO. QQRMs provide an opportunity for DHS to ascertain the progress each MCO is making in meeting quality goals and review quality initiatives. QQRMs also allow DHS to identify and share best practices as well as information obtained from interactions with CMS and other state managed care programs.

Monitoring is also completed through the ongoing review of performance reports. A key component to achieving DHS's quality goals is to provide data that is accurate and clearly reflects the performance of the MCOs/Primary Contractor in managing the delivery of health care to their members. These data elements are necessary to measure performance against program standards. DHS requires annual, biannual, quarterly, and monthly reports for several performance metric results. The MCOs submit the results using state-specific definitions and required timeframes for calculation and reporting.

Sanctions

When a HealthChoices MCO/Primary Contractor or CHIP MCO fails to comply with the standards of its agreement, DHS has various intermediate sanctions available to promote compliance. Each agreement contains provisions that outlines the sanctions and penalties that may be imposed for failure to meet performance and program standards as outlined.

Sanctions may be imposed when an MCO/Primary Contractor acts or fails to act as follows:

- Fails substantially to arrange for Medically Necessary services that the MCO is required to provide under law or under its Agreement.
- Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid Program.
- Acts to discriminate among Members on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS, DHS, Members, potential Members, or Health Care Providers.
- Fails to comply with requirements for Performance Improvement Programs (PIPs) as set forth in 42 CFR § 438.330.
- Fails to comply with the Agreement requirements pertaining to Program Integrity and Fraud, Waste and Abuse.
- Has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHS or that contain false or materially misleading information.

DHS may impose sanctions for the reasons stated above depending on the nature and severity of the noncompliance. Possible sanctions and penalties include but are not limited to:

- Imposing civil monetary penalties of a minimum of $1,000.00 per calendar day per violation for noncompliance.
- Withholding all or part of the Capitation Payments or State-Funded Residential Habilitation Subsidies.
- Fines or penalties consistent with those applied to nursing facilities or ICFs/ID in the Commonwealth.
- Requiring the submission of a corrective action plan.
- Suspending or limiting enrollment of new recipients.
- Preclusion or exclusion of the MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest in accordance with 42 U.S.C. § 1320a-7, 42 CFR Parts 1001 and 1002; 62 P.S. § 1407 and 55 Pa. Code §§ 1101.75 and 1101.77.
- Temporary management subject to applicable Federal or State law; and/or
- Termination of the Agreement.

DHS gives the MCO ten days advance written notice before it applies sanctions to the MCO.

These sanctions may, but need not be, progressive. DHS maintains an effective, reasonable, and consistent sanctioning process as deemed necessary to protect the integrity of the Medicaid program.

Framework for Quality Improvement

Quality Management Program

DHS requires HealthChoices and CHIP MCOs to maintain systems that document implementation of the written quality management program description. The MCO must also develop and implement monitoring mechanisms that are consistent with the MCQS, such as:

- An annual program description that documents the MCO's monitoring strategy across all services, all treatment modalities, and all sub-populations.
- An annual program evaluation that details all quality management program activities including, but not limited to, studies and activities undertaken, including the rationale, methodology and results, subsequent improvement actions, and aggregate clinical and financial analysis of Encounter, HEDIS®, Consumer Assessment of Healthcare Providers & Systems (CAHPS®), Medicaid adult core and Medicaid/CHIP child core, nursing facility measures, Pennsylvania Performance Measures (PAPMs), KAS measures, PIPs, and other data requested by DHS.
- A work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all quality management activities, including, but not limited to:
    - Data collection and analysis.
    - Evaluation and reporting of findings.
    - Implementation of improvement actions where applicable.
    - Individual accountability for each activity.

DHS requires that each of the MCOs Quality Management and Utilization Management Programs include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services. The programs must include professionally developed practice guidelines of care written in measurable and accepted professional formats, based on scientific and reliable clinical evidence or a consensus of providers in the particular field, and applicable to providers for the delivery of certain services. Practice guidelines must address the full range of health care needs of the populations served by the MCO and must be reviewed at least annually and approved by the MCO's internal Quality Improvement Committee. DHS utilizes Medical Directors, with the support of registered nurses, to review and approve MCO prior authorization review policies, evaluate complex cases, and review discrepancies from the assessment process.

Member Satisfaction

DHS contractually requires all MCOs to conduct a member satisfaction survey on at least an annual basis. For PH, CHC, and CHIP MCOs, this includes the collection of annual member satisfaction data through application of the CAHPS® instrument. The MCOs contract with independent CAHPS® survey organizations that are accredited as required by the NCQA to administer the survey. The CAHPS® survey organizations administer the survey annually to a statistically valid random sample of clients enrolled in the managed care program at the time of the survey. The standardized survey tool includes questions designed to assess specific dimensions of client satisfaction with providers, services, delivery, and quality, including but not limited to:

- Overall satisfaction with MCO services, delivery, and quality.
- Member satisfaction with the accessibility and availability of services.
- Member satisfaction with quality of care offered by the MCO's providers.

DHS requires that PH, CHC, and CHIP MCOs:

- Conduct, as applicable to the population they serve, an adult, child, CHIP and HCBS survey using the current version of the CAHPS® survey tool.
- Customize the surveys for Pennsylvania as directed by DHS.
- Include all Medicaid core questions.
- Include all supplemental and state specific questions as directed by DHS.
- Submit validated CAHPS® results annually by established due dates to DHS.

DHS requires all PH, CHC, and CHIP MCOs to conduct annual provider satisfaction surveys. Provider responses to the survey questions assist the MCOs in identifying areas for improvement and developing action plans. Providers that participate in the survey include PCPs, specialists, dental providers, hospitals, LTSS providers and providers of ancillary services. DHS requires these MCOs to report on provider survey results and actions taken in response to survey results.

OMHSAS conducts satisfaction surveys done by local Consumer/Family Satisfaction Teams contracted with the Behavioral HealthChoices Primary Contractors. OMHSAS alsoconducts member satisfaction surveys on an annual basis. This includes the collection of annual participant satisfaction data through application of the Mental Health Statistics Improvement Program (MHSIP) instrument. This instrument is a nationally recognized survey used to collect perception of care.

For each of the MCOs, DHS staff reviews grievance and appeals logs and reports on a regular basis. DHS also performs regular audits of the MCO grievance and appeals processes. The findings that are developed are communicated directly to the MCO and are also shared with DHS contract managers. In addition, data from the reports are used in MCO Comparative Reporting and other types of public reports.

Performance Improvement Projects

DHS requires its External Quality Review Organization (EQRO) to track PIPs, as well as validate and analyze the PIP proposals, interventions and compliance standards for all the managed care programs as per 42 CFR § 438.330. Each MCO and BH Primary Contractor assess the problem statement and goal and analyze their data to create a plan proposal. For Behavioral HealthChoices, each BH Primary Contractor has the responsibility of oversight of the BH-MCO Performance Measure and PIP activities to meet the federal requirements.

OMAP and OMHSAS began a new PIP cycle in 2020 which will run through at least 2024. Together the Physical and Behavioral HealthChoices programs are aligning one PIP towards Opioid/Substance Use Disorder (SUD) treatment.

- OMAP will be studying opioid prevention, harm reduction, coordination and facilitation into treatment and increased medication-assisted treatment utilization.
- OMHSAS will be studying SUD/Opioid treatment access, engagement in treatment and increasing the SUD counseling component along with the pharmacological component of the Medication Assistance Treatment.

OMAP is also implementing a PIP that focuses on reducing preventable admissions and readmissions and emergency department visits.

At the beginning of CHC implementation, OLTL began working with both the EQRO vendor, Island Peer Review Organization (IPRO), and the CHC-MCOs in developing and implementing the three-year PIP to start on January 1, 2019 for the Southwest region, January 1, 2020 for the Southeast region and January 1, 2021 for the remainder of the state. The areas of focus include clinical and non-clinical strategies in strengthening care coordination of LTSS and other types of health care between Medicaid and Medicare, and nursing home transition to the community.

CHIP's PIPs focus on improving performance in Developmental Screening in the First Three Years of Life and Lead Screening.

ODP's PIP concentrates on decreasing social isolation among ACAP members.

Pay for Performance

Pay-for-Performance (P4P) is a value-based purchasing arrangement which provides incentive payments and/or penalties linked to performance. DHS implemented an Integrated Care Plan (ICP) P4P program between the PH-MCOs and BH-MCOs/County BH contractors focusing on improving care for those with serious persistent mental illness (SPMI) and those living with substance use disorder (SUD). The PH-MCOs and BH-MCOs/County BH contractors must collaborate on identifying individuals with SPMI, establish a joint care plan and notify each other of inpatient stays within one business day. If MCOs achieve those process measures, they are eligible for an incentive payment on five quality measures. DHS is looking into expanding the number of measures and including health equity quality measures the MCOs are eligible to receive an incentive for. In addition, DHS is looking to expand the disease states beyond individuals with SPMI.

Physical HealthChoices also offers an MCO P4P program. OMAP chooses P4P quality measures based on an analysis of past data indicating the need for improvement across the HealthChoices program as well as the potential to improve health care for a broad base of the HealthChoices population. The P4P payout structure is based upon the PH-MCO meeting designated benchmarks for the chosen quality measures. Starting in 2019, PH-MCOs were eligible to earn an additional benchmark incentive payout if they met a higher benchmark for a set of quality measures. We refer to this additional benchmark payout as a bonus bundle payout. In addition to the benchmark payouts, there is an opportunity for the PH-MCOs to earn dollars for incremental improvement performance. If the PH-MCO does not meet the benchmarks that have been established for the P4P program, there is an offset penalty. OMAP is looking to incorporate health equity measures into the MCO P4P program in the future.

In addition to the MCO P4P program, OMAP requires the PH-MCOs to implement a Provider P4P program. To align programs, the quality measures are the same as the MCO P4P program. Eligible providers can earn an incentive payment for closing gaps in care.

Behavioral HealthChoices is evaluating a P4P program in performance measurement after creating performance goals based on HEDIS® percentile performance benchmarks and yearly improvement goals for all the Primary Contractors.

CHIP is also working towards developing a P4P incentive program for CHIP MCOs in the future. The intent for CHIP P4P will be to reward MCOs monetarily for meeting or exceeding benchmarks for a predetermined set of healthcare performance measures. CHIP projects the first-year awards will include incentives for obtaining benchmarks for existing MCOs and any newly procured MCOs. First-year rewards will also include payouts to existing MCOs for incremental increases. No penalties will be applied the first year if an MCO does not meet the minimum benchmark threshold. Penalties will be considered for future versions of P4P.

The DHS program offices are considering having, in the future, an aligned P4P program where physical health, behavioral health, and CHC plans are jointly measured.

Performance Measures

Program Offices use a combination of national performance measures from measure sets including the National Committee for Quality Assurance's HEDIS® set, National Quality Forum (NQF) measures, and the CMS Core Sets, including Adult, Child, and Behavioral Health. Appendix E indicates the current or planned reporting status of each of the BH Core Set Measures for the Physical Health and Behavioral HealthChoices programs in order to comply with federal law by 2024. Please note that CHIP MCOs cover both physical and behavioral health services. NCQA recently released new LTSS measures focused on comprehensive assessments and re-assessments and the sharing of care plans and inpatient discharge.

In addition to these national measures, MCOs also collect Pennsylvania Performance Measures (PAPMs), which are a set of state quality measures that were developed focusing on specific areas of importance to the Commonwealth that are not captured through other available data sets. PAPMs use statistically valid methodologies and allow program offices to track program performance over time. MCOs are required to report specific data for measures according to the requirements of the managed care program(s) in which

they participate, and the most current year's measures selected. Data sources include, but are not limited to, encounter data, participant interviews, patient experience surveys, on-site documents, electronic file reviews, quarterly, and annual reports. For example, OMHSAS uses the MHSIP instrument, which is a nationally recognized survey used to collect perception of care surveys in domains such as cultural sensitivity, functioning, general satisfaction, participation in treatment planning, and quality and appropriateness of mental health services. OMAP, OLTL, and CHIP all use the Agency for Healthcare Research and Quality's CAHPS® survey tools.

Please refer to Appendix F, which lists the measures collected and survey tools used by each managed care program.

Health Equity

In accordance with 42 CFR § 438.340, states must identify as part of their quality strategies efforts to "identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status." As in many states, health disparities are a serious issue in Pennsylvania. A baby born in North Philadelphia has a life expectancy of just 68 years, when 5 miles to the south, the life expectancy is 88 years. As such, in 2019, DHS added a section in our Strategic Plan to promote health equity. This help set a collective vision moving forward as a department, with each program office playing a role.

OMAP has the most experience measuring and analyzing disparities. For the past several years, OMAP shared identified health disparities with the PH-MCOs, but disparities have persisted. As a result, OMAP will begin linking 10% of the 2021 MCO P4P Program payment to the African American Community specifically, starting with an incremental improvement payout for maternity and well-child measures for care rendered in 2020. In 2022 and ongoing, OMAP will evaluate disparities and if any additional measures should be added.

In addition, in 2019, OMAP added language into the agreements that required PH-MCOs to either achieve, or be working towards, the attainment of the NCQA distinction in Multicultural Health Care; OLTL added the same requirement for CHC-MCOs for 2021. This distinction recognizes MCOs that adopt best practices for collecting race, ethnicity, and language data, for providing language assistance, for cultural responsiveness, and for reduction of health disparities. Pennsylvania is home to the first MCO in the country to achieve this designation (Health Partners Plans) and six PH-MCOs have achieved this designation in total. DHS is considering expansion of this requirement across all program offices that contract with MCOs.

OMHSAS has begun to analyze HEDIS® measure data stratified by demographic characteristics, including age, race, ethnicity, gender, geographic location, and MCO. Additionally, the ICP quality measures are being stratified by these characteristics as well. The results will be shared with the primary contractors and BH-MCOs.

OLTL is assessing its available data to start measuring disparities. OLTL has identified FED assessments, claims data, and HEDIS® measures as several data sources that could be used to identify disparities, and will begin analysis in 2020.

CHIP is simultaneously also conducting preliminary analyses with its encounter data to identify possible disparities to track over time.

External Quality Review

DHS contracts with IPRO as the EQRO that serves all managed care programs. The EQRO performs the mandated standard external quality review (EQR) activities that are required as part of 42 CFR Part 438, Subpart E. The current contract was signed in June 2018 for a term of three years, with two additional one-year renewal options. IPRO's core products and services include quality measurement and improvement surveys and studies, utilization and diagnosis-related group management, encounter data validation, quality assurance, and health care process design and measurement activities. Information from the EQR is used to develop the Annual Technical Report required by 42 CFR §§ 438.350-370. IPRO does not use information from a Medicare or private accreditation review of an MCO for the Annual Technical Report

instead of conducting one or more of the EQR activities described in 438.358(b)(1)(i) through (iii). For an example of an Annual Technical Report, please see the BH-MCO reports located at http://www.healthchoices.pa.gov/info/resources/publications/behavioral/index.htm. Additionally, IPRO subcontracts with ACQURATE, which is licensed by the National Committee for Quality Assurance to conduct HEDIS® audits and develop "report cards" to display HEDIS®, CAHPS®, and PAPM results.

Each program office uses similar processes to work with IPRO and receives similar services from the vendor. DHS offices make available to IPRO all tools, processes, and monitoring results. IPRO uses this information to validate reporting from the MCOs. There are a few specific initiatives from various offices that are worth mentioning. For example, OMHSAS uses the EQRO to validate each BH-MCO's compliance status with Performance Measures and the PIP, which are included in the Primary Contractor's Quality Assurance and Performance Improvement work plan. Additionally, ODP uses the EQRO to annually determine KAS's compliance with the ACAP agreement and all managed care regulations.

In 2019, IPRO, along with CHIP staff, initiated a process to conduct a baseline assessment of the CHIP MCOs' encounter data submission processes and to identify potential issues that may impact the completeness and accuracy of encounter data submitted by the CHIP MCOs. The CHIP MCOs were required to complete an Information Systems Capabilities Assessment tool. The purpose of this assessment is to pose standard questions to be used to assess the strength of a CHIP MCO with respect to producing valid encounter data, performance measures, tracking encounter data submissions and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees.

Strategic Agreement Alignment

DHS recognizes the importance of aligning initiatives across program offices. By aligning initiatives, DHS eases administrative burden and focuses population health efforts for frontline providers and health systems. Many of the successful quality initiatives born out of a single program office will be expanded to other program offices as appropriate. Given that most of Medicaid operates through the managed care delivery system, DHS will strive to align its agreements with MCOs wherever possible. DHS has identified certain priority areas for alignment that include health equity, value-based payments, and SDOH, all discussed elsewhere in this strategy.

Bend the Healthcare Cost Curve

Value Based Payment

Value Based Payment (VBP) is a DHS initiative to transition providers to being paid for the value of the services provided, rather than simply the volume of services. VBP strategies and VBP models are critical for improving quality of care, efficiency of services and reducing cost.

As each of the program offices are at different stages in the maturity of their VBP programs and vary in structure, DHS began working on a VBP alignment initiative in 2019. The guiding principles of this alignment include:

(1) Bend the cost curve.
(2) Improve quality of care.
(3) Multi-payer alignment.
(4) Meeting patients and providers where they are.
(5) Promoting health equity.

One of the goals is to define a common framework with standardized payment strategies in which all program offices can operate and implement by 2022. These strategies include Performance-Based Contracting, Shared Savings, Shared Risk, Bundled Payments and Global Payments. Programs may identify required and/or recommended VBP models specific to its service system needs that fit into the uniform framework. Another goal is to standardize VBP reporting requirements for primary contractors/MCOs and the evaluation process utilized by program offices. Currently, there is some level of reporting required of PH-MCOs and BH-MCOs, although there are significant differences. Additionally, each program office does or will include VBP medical spend requirements in the agreements with its primary contractors/MCOs, with the goal of increasing the requirement each contract year.

Efficiency Adjustments

Medical efficiency analyses are value-based strategies that create cost savings when building up capitation payments by identifying inefficiencies and waste. This is accomplished through evidence-based approaches that identify potentially preventable events or avoidable health care costs within medical services. Services such as inpatient admissions, emergency room visits, and pharmacy are targeted for these cost savings. Beyond the cost savings in the buildup of the capitation rates, the efficiencies also incentivize timely and appropriate care through innovative MCO initiatives aimed to improve health outcomes for Pennsylvania MA enrollees. This is because MCOs can improve their profitability if they are able to achieve or surpass the efficiencies accounted for in the capitation rates.

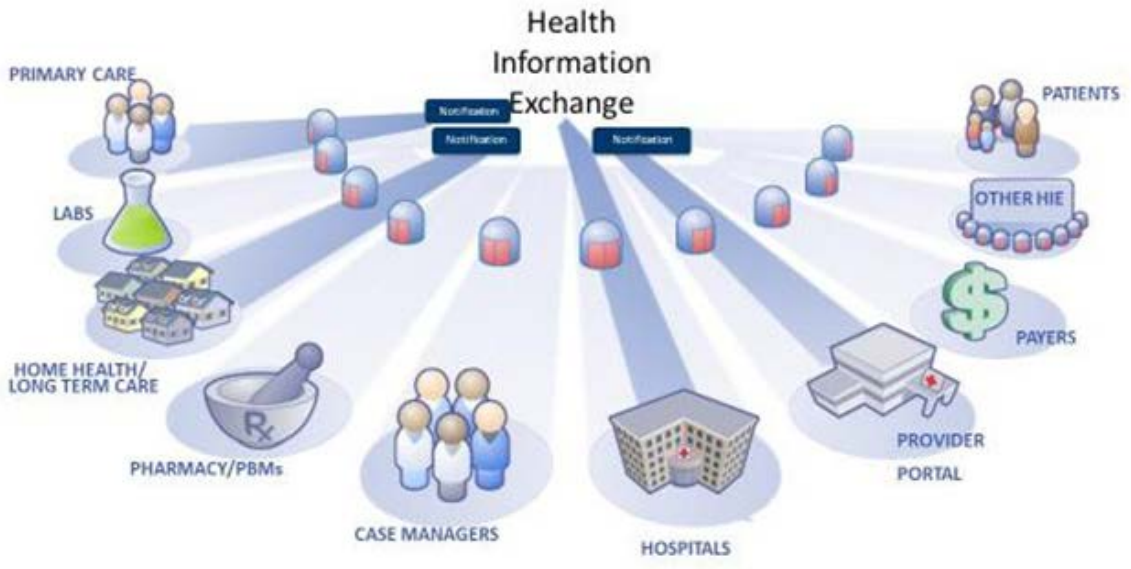
Health Information Technology

Pennsylvania has positioned itself as a leader among state Medicaid programs in utilizing Health Information Technology to improve the quality and cost effectiveness of service delivery. DHS views both provider and system level utilization of electronic information as fundamental to quality care.

DHS realizes that real-time patient level clinical data is necessary to advance its quality strategy and improve utilization of services. Hospitals, care providers, and payors must become meaningful users of electronic health records (EHR). Electronic record usage is encouraged through the Medicaid EHR incentive program.

As patient level clinical data becomes available electronically, the rapid, secure exchange of this information becomes a critical link in building a quality health system. The PA Health Information Exchange (HIE) promotes this effective data transfer. The HIE, through the PA Patient and Provider Network (P3N), works to ensure interoperability and interconnectivity across all entities. The P3N consists of PA certified HIOs, PA Certified HISPS, and the Commonwealth Health Gateway. In the past two years, Pennsylvania has seen a rapid rise in EHR and HIE utilization, with the resulting benefit of real-time better care. DHS continues to encourage and incentivize both EHR and HIE utilization through several innovative programs.

Figure 4. Health Information Exchange Schematic.



Improvements and Interventions

Pennsylvania's managed care programs utilize pilot and demonstration initiatives to advance specific DHS priorities in innovative ways that allow for flexibility and proof of concept. Each of these prioritized initiatives relate directly back to DHS goals of increasing access, improving quality, and curbing rising costs. DHS engages in ongoing evaluation and assessment of the progress and impact of these pilots. When pilots prove successful, efforts are made to incorporate them into the broader managed care program by bringing them to scale and identifying sustainable funding sources. For a list of DHS current initiatives, please refer to Appendix G.

Social Determinants of Health

One category of improvements that warrants specific discussion relates to SDOH. The HealthChoices Agreements define SDOH as the conditions in which people are born, grow, live, work, and age. For over a year, DHS has led a comprehensive stakeholder engagement process to assist in the development and adoption of a statewide strategy to address SDOH.

SDOH do not exist in silos, but they often interact and build off each other and can be barriers to physical and mental health and economic well-being. Individuals also face barriers in accessing information on how to obtain the services that may address SDOH needs.

DHS will procure and implement a person-centered, statewide Resource and Referral Tool (R&RT) to assist individuals with obtaining meaningful information and access to the services they need to achieve overall wellbeing, positive health outcomes, and financial self-sufficiency. The R&RT will 1) facilitate SDOH assessments throughout the Commonwealth, and 2) adopt a platform to refer individuals with identified SDOH needs to resources, community-based organizations, faith-based entities, and state and local government agencies that can help address them. The domains that will be required as part of the SDOH assessments include food insecurity, health care access and accessibility, housing, transportation, childcare, employment, utilities, clothing, and financial strain.

There are many evidence-based interventions that address SDOH, including through the use of community-based organizations These interventions can improve health outcomes while decreasing health service utilization and costs. However, DHS is examining how community-based organizations that address SDOH and reduce cost can be incorporated into innovative value-based models. DHS plans to create a roadmap that outlines its expectations for how MCOs can address SDOH, in partnership with community-based organizations, and will include language about SDOH in the HealthChoices agreements for 2021.

Conclusion and Opportunities

Best Practices

DHS considers its QQRMs with each MCO to review its performance against certain metrics a promising practice because it encourages continuous process improvement, collaboration, rapid response to identified issues, and open dialogue.

DHS's Opioid Use Disorder (OUD) Centers of Excellence (COE) model has been recognized nationally as a promising practice for treating individuals with OUD. COEs focus on utilizing interdisciplinary community-based care management (CBCM) teams to provide recovery support services has shown demonstrable improvement in initiation and duration of OUD treatment. The use of CBCM in this context is considered a best practice, but CBCM more generally can also be considered a best practice because of the improved patient engagement it generates.

Finally, the DHS PeopleStat structure is a promising practice. By bringing together each of DHS's program offices on a weekly basis to review a specific departmental priority and performance against related objectives, DHS engages in continuous process improvement. Its own internal operations, as well as those of its various contracted MCOs, are reviewed and discussed regularly. By bringing all program offices together, diverse perspectives are represented and alignment across programs is encouraged.

Challenges

Due to Pennsylvania's separate physical and behavioral health delivery systems, it can be challenging for MCOs to provide comprehensive and integrative services to individuals. Behavioral and physical health integration necessitates sharing of data between the two managed-care programs enabling the plans and providers to more effectively and more robustly manage complex medical issues. Pennsylvania, through the eHealth Partnership Authority, is working to develop interconnections of the regional HIEs which will allow the appropriate sharing of information to effectively treat and manage complex medical issues. DHS continues to explore ways to facilitate the delivery of comprehensive and coordinated care to the individuals served through its managed care delivery system.

Although behavioral health providers were excluded from the Medicare and Medicaid Electronic Health Record Incentive program, a significant number of these providers have purchased EHR systems; although the majority do not have interoperable connectivity to an HIE. DHS's goal is to incentivize all HealthChoices providers to connect with a Pennsylvania Patient and Provider Network (P3N) Certified Health Information Organization to improve coordination of care and tracking of outcomes from a quality perspective.

There is a need for improved alignment among the various Medicaid managed care programs as well as among the various MCOs within those programs. Providers who participate in multiple programs or in the networks of multiple MCOs are challenged by variance in the terms of their agreements and the array of metrics that they are required to report. Increased alignment could decrease the amount of provider time spent on administrative and compliance-related tasks, allowing them to focus on the provision of quality care to patients. With the implementation of CHC, the state has taken steps in ensuring all plans operating in Pennsylvania are coordinating care and sharing of information when a member is being served either by a Medicaid plan or a Medicare plan. There are ten Dual Special Needs Plans in operation in the state; three are aligned with CHC and the other seven are not. This has allowed DHS to expand care coordination between both systems by requiring extensive reporting requirements and data sharing via the Medicare Improvements for Patients and Providers Act contracts with all plans.

Recommendations

In addition to addressing the above challenges of integration and alignment, DHS will continue its focus on maturation and expansion of VBP initiatives to incentivize the provision of high-quality services. This will be accomplished through developing or refining P4P initiatives, PIPs, and bundled payment arrangements. The success of VBP initiatives is highly dependent on the accuracy and timeliness of the outcomes reporting, so a continued focus on health information technology will be necessary.

DHS is committed to identifying ways in which the managed care delivery system can address SDOH to improve the quality of life of the individuals it serves. As DHS explores the provision of supportive housing services to individuals with OUD through a federal Substance Abuse and Mental Health Services Administration grant, it will consider best practices and options to sustain those practices beyond the grant funding period. DHS is also particularly interested in ensuring that individuals with disabilities have access to housing that meets their needs. DHS will explore ways to improve the provision of Supplemental Nutrition Assistance Program benefits, employment and training services, transportation to and from medical appointments, and subsidized childcare.

DHS will continue to explore innovative ways to provide quality services to the vulnerable populations that it serves, such as children with complex medical needs. DHS will continue to integrate the CHIP program to better leverage Information Technology resources and programs to strengthen the quality strategy procedures that were already in place. CHIP and Medicaid are better able to align their practices to improve operations and quality of services within both offices that are now under OMAP.

Appendices

Appendix A. Managed Care Goals and Objectives.

Increase Access to Healthcare Services				
Physical HealthChoic	Behavioral HealthChoices	Community HealthChoices	CHIP	ACAP
Goal: Incentivize Integrated Care Plans for individuals with serious mental illness		Goal: Deliver improved quality and coordination of care and ensure participant access to continuous services that enable, maintain, and improve physical and behavioral health outcomes and quality of life.	Goal: Ensure appropriate utilization of services by children enrolled in CHIP.	Goal: Provide coordinated care to individuals with autism in the communities where they live, work, and are actively involved
Objective 1: Increase initiation and engagement in alcohol and other drug dependence treatment. Objective 2: Improve adherence to antipsychotic medication for individuals with schizophrenia. Objective 3: Decrease emergency room utilization and inpatient admissions and readmissions for individuals with serious mental illness.		Objective 1: Improve service planning and care coordination in LTSS. Objective 2: CHC-MCOs are expected to provide quality LTSS to participants and promote continuous improvement through established quality management and performance improvement processes. Under the CHC Agreement, MCOs are required to have written quality management plans, strategies, and quality improvement programs that clearly define quality improvement structures and processes through the assignment of responsibility to appropriate individuals. CHC-MCOs will also be required to report national, state-specific quality measures and meet CMS waiver assurances. Objective 3: To ensure participant access to nursing facility services and continuity of services for nursing facility residents for medically necessary care.	Objective 1: Decrease emergency department and inpatient utilization. Objective 2: Increase percentage of children attending annual dental visits.	Objective: Increase the percentage of participants who had a follow-up appointment or visit within 30 days of a psychiatric hospitalization.

Improve Quality of Healthcare Services				
Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	CHIP	ACAP
Goal: Utilize monitoring and incentive tools to push MCOs to improve key performance indicators.				
Objective 1: Improve opioid stewardship, promote harm reduction strategies, and improve coordination and facilitation into treatment for opioid use disorder. Objective 2: Reduce number of preventable admissions and readmissions and reduce inappropriate emergency department utilization.	Objective: Increase length of engagement in treatment for substance use disorders through counseling and Medication Assisted Treatment.	Objective 1: Work to improve quality of care and services through the identification of processes and tools. Objective 2: Determine interventions for quality improvement based on review and analysis of baseline data, results of quality improvement activities, and ongoing assessment of participants' physical and behavioral health care and LTSS needs. Objective 3: Focus MCO PIPs on strengthening care coordination of LTSS and other types of health care and transitioning from the nursing home to the community.	Objective 1: Increase rates of developmental screening in the first three years of life. Objective 2: Increase rates of lead screening.	Objective: Decrease social isolation among ACAP members.

Bend the Healthcare Cost Curve				
Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	CHIP	ACAP
Goal: Lead the healthcare system toward value-based payment coordinated across payers.				
Objective 1: Coordinate across payers: Lead VBP coordination across PH-MCOs to align provider incentives and reduce burden Objective 2: Expand VBP in physical health: Expand and mature value-based payment initiatives in physical health Objective 3: Leverage Health Information Exchange: Increase the number of providers and payers participating in electronic health information exchange; expand electronic encounter notification service statewide; and expand and streamline public health reporting and retrieval through the Public Health Gateway	Objective 1: Expand VBP in behavioral health Objective 2: Collaborate with stakeholders to standardize VBP outcome performance measures	Objective 1: Implement VBP for HCBS: Develop and implement value-based payment initiatives for HCBS to improve outcomes for supporting HCBS, including incentivizing community-based living and nursing home transition, person-centered planning, and care coordination. Objective 2: Develop and implement educational programs and VBP initiatives for Nursing Facility Services: In coordination with nursing facility representatives, implement educational programs and value-based payment initiatives to improve care coordination and health and safety outcomes for nursing facility participants. This includes initiatives supporting improvements such as reducing hospitalizations, reducing pressure ulcers, improving immunization rates, reducing falls, and reducing the use of antipsychotic medications	Objective: Explore mechanisms to integrate VBP into CHIP using the next CHIP RFA.	Objective 1: Explore mechanisms to integrate VBP into ACAP. Objective 2: Develop quality measures (and treatment models linking them to process measures) to be used in VBP pilots.

Appendix B: Access Standards

The HealthChoices Agreement and its exhibits are found at http://www.healthchoices.pa.gov/info/resources/publications/physical/index.htm.
The Behavioral HealthChoices Program Standards & Requirements and appendices are found at http://www.healthchoices.pa.gov/info/resources/publications/behavioral/index.htm.
The Community HealthChoices Agreement and exhibits are found at http://www.healthchoices.pa.gov/info/resources/publications/community/supporting-documents/index.htm.
The ACAP Agreement and appendices are found at https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/ACAP.aspx.
The CHIP documents are found at http://www.chipcoverspakids.com

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
438.206: Availability of Services					
Maintain and monitor a network of appropriate providers	HealthChoices Agreement: Section V.F.16. Provider Directories, Section V.S. Provider Network, Section VIII.B.4. Provider Network, Exhibit AAA Provider Network Composition/ Service Access	HealthChoices Behavioral Health Program-Program Standards and Requirements, January 1, 2020 ("PS&R"), Part II-4., C. Coordination of Care Sections 1.h, 1.k., 1.m. and 1.x; Part II-5, E. Provider Enrollment	CHC Agreement Section IV(A), Certification, Licensing and Accreditation. CHC Agreement Section V(BB), relating to Provider Network. CHC Agreement Section V (BB)(1) relating to Provider Qualifications.	ACAP Agreement: Article 2.5 Administration, Section G.1, Purchase of Service Subcontracts with Providers and Section H.5.d, Provider Selection; Article 6.1 Quality Management, Section A.2 and A.3.	CHIP State Plan Amendment (SPA) 18-0001, Section7.2; PA Code Title 28 Section 9.679 (c)(d)(e)(m) Section 9.681 (d) IFB #6100024102 Section L Version 2/8/13;Sole source grant amendment 1 addressing 42 CFR 457.1218; CHIP Procedures Handbook 21.9 Provider Network Composition/ Service Access.
Provide female enrollees direct access to women's health specialists	HealthChoices Agreement: Section V.A.6. Self-Referral/Direct Access	N/A	CHC Agreement Section V(A)(6), Self-Referral/Direct Access.	ACAP Agreement: Article 2.1 Service Provision, Functions and Duties of the Contractor, Section Q	PA Code Title 28 Section 9.682; PA Code Title 31 Section 154.12; Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Appendix B; CHIP Eligibility and Benefits Handbook: Women's Health Services.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Provide for second opinions	HealthChoices Agreement: Exhibit AAA1.r Second Opinions	PS&R, Part 11-4, D, Member Services/Member Rights, Section 2.e.xxiv.g.	CHC Agreement Exhibit M (41) CHC-MCO Participant Handbook. CHC Agreement Exhibit T (1)(s): Second Opinions.	ACAP Agreement: Article 2.1 Service Provision, Functions and Duties of the Contractor, Section T	Sole source grant amendment 1 addressing 42 CFR 457.1230. CHIP State Plan Amendment (SPA) 18-0001, Section 6.2.4 and Appendix B; CHIP Eligibility and Procedures Handbook: Surgical Services.
Provide out-of-network services when not available in-network	HealthChoices Agreement: Section V.S. Provider Network	PS&R Appendix VPSR at 11-4 Tasks; A; 4; b	CHC Agreement Exhibit T(1)(e) Out-of-Network Access.	ACAP Agreement: Article 2.1 Service Provision, Functions and Duties of the Contractor, Section O	PA Code Title 28 Section 9.679 (k) and Section 9.681 (c); IFB #6100024102 Section L (3) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230, Expires 2/29/2020; CHIP State Plan Amendment (SPA) 18-0001, Section 7.2.2.
Coordinate payment of out-of-network providers	HealthChoices Agreement: Section V.S. Provider Network	PS&R, Part II-4, A, State Plan Services, Sections 4.b, F, Financial and Reporting; Part II-7. K, I2.	CHC Agreement Section VII(e)(4) Payments for Out-of-Network Providers.	ACAP Agreement: Article 2.1 Service Provision, Functions and Duties of the Contractor, Section O	PA Code Title 28 Section 9.679 (k) and Section 9.681 (c); CHIP State Plan Amendment (SPA) 18-0001, Section 7.2.2.
Demonstrate that all providers are credentialed	HealthChoices Agreement: Exhibit M (1), Standard VIII., contains credentialing standards.	PS&R, Part II-5, D, Provider Network/Relations, Section 2; Part II-5, E, Provider Enrollment Credentialing/ Recredentialing; and Part II- 5, F, Service Access, Sections 4 and 11.	CHC Agreement Exhibit F, Standard VIII: Credentialing/ Recredentialing Providers. CHC Agreement Section V(BB)(1) relating to Provider Qualifications.	ACAP Agreement: Article 2.5 Administration, Section G.2.i and H.2.b	Sole source grant amendment 1 addressing 42 CFR 457.1230. CHIP Procedures Handbook Chapter 21.11.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Meet state standards for timely access to care and services	HealthChoices Agreement: Exhibit AAA1Network Composition	PS&R Part II-4, A, State Plan Services, Sections 1, and 7 Part II-5, F, Service Access	CHC agreement Section V(BB)(2) and Exhibit T(1): Provider Network Composition/ Service Access. CHC Agreement Section IV(D): General Laws and Regulations.	ACAP Agreement: Article 2.5 Administration, Section H.4.d and Article 6.1 Quality Management, Section A.2	PA Code Title 28 Section 9.651 (c) emergency services Section 9.679 (d)(e)(f)(g); IFB #6100024102 Section M (e) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230.
Ensure hours of operation are no less than those offered to commercial insureds	HealthChoices Agreement: Section V.R. Provider Services	PS&R Part II-4, A, State Plan Services, Section 2; Part II-5, F, Service Access, Section 1.	CHC Agreement Exhibit T(1)(k): Participant's Freedom and Choice and Exhibit T(2)(a): general appointment standards.	Article 2.1 Service Provision, Functions and Duties of the Contractor, Section H	IFB #6100024102 Section M (e) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230.
Furnish all contractual services 24 hours a day, 7 days a week	HealthChoices Agreement: Section V.S.9 Twenty-Four Hour Coverage, Section V.G.2 PH-MCO Internal Member Dedicated Hotline	PS&R Part II-4, A, State Plan Services, Section 2; Part II-5, F, Service Access, Section 1.	CHC Agreement Section V(P)(1): General Participant Services and Section V(BB)(10): Twenty-Four-Hour Coverage.	ACAP Agreement: Article 2.1 Service Provision, Functions and Duties of the Contractor, Sections D and E	IFB #6100024102 Section M (e) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Monitor compliance of providers	HealthChoices Agreement: Exhibit A. Managed Care Regulatory Compliance Guidelines	PS&R Part I-5, On-Site Reviews; Part I-19, Project Monitoring; Part II-2, B, Specific Objectives, Section 1.b; Part II-3, E, Compliance with Federal & State Laws, Regulations, Department Bulletins and Policy Clarifications; Part II-3, F, False Claims; Part II-3, H, Performance Standards and Damages, Section 2; Part II-4, D, Provider Network and Relations, Section 2.); Part II-5, D, Provider Network/Relations Sections 3.j and 3.k; Appendix R.	CHC Agreement Exhibit C: MLTSS regulatory compliance guidelines	ACAP Agreement: Article 2.5 Administration, Section G; Article 6.1 Quality Management, Section A.2	Sole source grant amendment 1 addressing 42 CFR 457.1230, Expires 2/29/2020; CHIP Procedures Handbook Chapter 21: Managed Care Organizations Quality Requirements.
Provide culturally competent services	HealthChoices Agreement: Section V.S.2 Cultural Competency	PS&R Part II-2, B, Specific Objectives, Section 2.G.; Part II-5, D, Provider Network/Relations, Sections 1.b, 1.c, and1.e; Appendix CC	CHC Agreement Section V(BB)(3), relating to Cultural Competency, Linguistic Competency, and Disability Competency.	ACAP Agreement: Article 2.1 Service Provision, Section EE	IFB #6100024102 Section V (1)(2) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1207 and 1230. State Plan, Section 5.1.2 and section 5.3.

438.207. Assurances of Adequate Capacity and Services.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Assure and document capacity to serve expected enrollment	HealthChoices Agreement: Section V.O.5.m Management Information Systems Section V.S.4 Specialists/School Based Health Centers as PCPs, Exhibit AAA1 Network Composition	PS&R Part II-5, D, Provider Network/Relations, Section 1.	CHC Agreement Section V(BB): Provider Network and Exhibit T: Provider Network Composition/ Service Access.	ACAP Agreement: Article 2.1 Service Provision, Section G; Article 4.4 Enrollment, Section A.1	IFB #6100024102 Section L (2)(3) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Section 7.2.
Offer appropriate range of preventive, primary care and specialty services	HealthChoices Agreement: Section V.S. Provider Network, Exhibit AAA Provider Network Composition/Service Access	PS&R Part II-4, C, Coordination of Care; Part II-5, D, Provider Network/Relations, Section1.	CHC Agreement Section V(BB): Provider Network and CHC Agreement Exhibit T: Provider Network Composition/ Service Access.	ACAP Agreement: Article 2.1, Service Provision, Sections N and Q	IFB #6100024102 Section L (4)(b)(c) Version 2/8/13 IFB #6100024102 Section M (1)(a)(c),(2)(b),(3) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Section 6 and Appendix B.
Maintain network sufficient in number, mix, and geographic distribution	HealthChoices Agreement: Section V.S. Provider Network, Exhibit AAA Provider Network Composition/ Service Access	PS&R Part II-5, F, Service Access, Section 2.	CHC Agreement Section V(BB): Provider Network and CHC Agreement Exhibit T(1): Provider Network Composition/ Service Access.	ACAP Agreement: Article 2.5 Administration, Section H	IFB #6100024102 Section L Version 2/8/13; CHIP State Plan Amendment (SPA) 18-0001, Section 7.2.2.

438.208. Coordination and Continuity of Care.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Enrollees have ongoing source of appropriate primary care	HealthChoices Agreement: Section V.S.3. Primary Care Practitioner (PCP) Responsibilities	PS&R Part II-4, B, In Lieu Of and In Addition To Services, Section 2.	CHC Agreement Section V(Y): Selection and Assignment of PCPs. CHC Agreement Section V(BB)(4): Primary Care Practitioners Responsibilities. CHC Agreement Section V(BB)(5): Specialists as PCPs.	ACAP Agreement: Article 2.1 Service Provision, Section I	Section 9.684 (a)(1) IFB #6100024102 Section L Version 2/8/13; CHIP State Plan Amendment (SPA) 18- 0001, Section 7.2.
All services received are coordinated with services received from any other MCO	HealthChoices Agreement: Section V.D. Coordination of Care	Definitions: Priority Populations Page xiv. PS&R Part II-5 Requirements, D Provider Network/Relations, 3.g., h.	CHC Agreement Section V(J): Service Coordination.	ACAP Agreement: Article 2.1 Service Provision, Section L	IFB #6100024102 Section M(b) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Section 4.4.
Sharing with other MCOs serving enrollee with special health care needs results of identifications/ assessments to prevent duplication of services	HealthChoices Agreement: Exhibit NN Special Needs Unit	PS&R Part II-2 Objectives, 2 Program Objectives, i	CHC Agreement Section V(H): Care Management Plans. CHC Agreement Section V(J): Service Coordination. CHC Agreement Section V(M): CHC-MCO and BH-MCO Coordination.	ACAP Agreement; Article 2.1 Service Provision, Section L	Sole source grant amendment 1 addressing 42 CFR 457.1230.
Protection of enrollee privacy when coordinating care	HealthChoices Agreement: Section V.T.8. Confidentiality and Section	PS&R Part II-4, C, Coordination of Care, Sections C and D.	CHC Agreement Section V(CC)(10): Confidentiality.	ACAP Agreement: Article 2.1 Service	Sole source grant amendment 1 addressing 42 CFR 457.1230.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
	XIII Confidentiality		XIII: Confidentiality. CHC Agreement Exhibit B(1)(B): Confidentiality.		
State mechanisms to identify persons with special healthcare needs	HealthChoices Agreement: Section V.P. Special Needs Unit (SNU), Exhibit NN Special Needs Unit	PS&R Part II-4, C, Coordination of Care, Section H.	CHC Agreement Section V(E): Comprehensive Needs Assessments and Reassessments.	ACAP Agreement: Appendix A	Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Section 6.2.22; CHIP Procedures Handbook Sections 11.7.1, 21.19.19.2, 21.20.1, and 21.26.
Mechanisms to assess enrollees with special healthcare needs by appropriate healthcare professionals	HealthChoices Agreement: Section V.P. Special Needs Unit (SNU), Exhibit NN Special Needs Unit	Program Evaluation Performance Summary (PEPS) review standard 28.1	CHC Agreement Section V(E): Comprehensive Needs Assessments and Reassessments.	ACAP Agreement: Article 2.1 Service Provision, Section K.1-8, Section L	IFB #6100024102 Section N (6) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230, Expires 2/29/2020; CHIP State Plan Amendment (SPA) 18-0001, Section 11.7.1, 6.2.22; CHIP Procedures Handbook Sections 21.20.1, and 21.26.
Treatment plans developed by PCP with enrollee participation and in consultation with specialists; approved in a timely manner; and in accord with applicable state standards	HealthChoices Agreement: Section V.S.4. Specialists/School Based Health Centers as PCPs	PS&R, Part II-4, A, State Plan Services, Section 7.	CHC Agreement Sections V(E thru J): Comprehensive Needs Assessments and Reassessments; Person-Centered Planning Team Approach Required;	ACAP Agreement: Article 2.1 Service Provision, Section K.1-8	State Plan Amendment (SPA) Section 3.6.17; CHIP Procedures Handbook Section 21.10.4

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
			Person-Centered Service Plans; Care Management Plans; Department Review of Changes in PCSPs; and Service Coordination.		
Direct access to specialists for enrollees with special healthcare needs	HealthChoices Agreement: Section V.S.4. Specialists/School Based Health Centers as PCPs	PS&R, Part II-4, C, Coordination of Care, Section H.	CHC Agreement Section V(BB)(5): Specialists as PCPs.	ACAP Agreement: Article 2.1 Service Provision, Section N	IFB #6100024102 Section J (5) Section M (3) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Section 6 and Appendix B.
438.210. Coverage of Authorized Services.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Identify, define, and specify the amount, duration, and scope of each service	HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope and Section V.B.1. General Prior Authorization Requirements	PS&R Appendix AA. B Guidelines for review Appendix T Guidelines for Medical Necessity Review	CHC Agreement V(A)(1): Amount, Duration and Scope. CHC Agreement Section V(B)(1): General Prior Authorization Requirements.	ACAP Agreement; Article 2.4 Service Authorization, Section N	Sole source grant amendment 1 addressing 42 CFR 457.1230, Expires 2/29/2020; CHIP State Plan Amendment (SPA) 18-0001, Section 6 and Appendix B; Eligibility and Procedures Handbook.;
Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope and Section V.B.1. General Prior Authorization Requirements	PS&R Part II-4, A 1, State Plan Services	CHC Agreement V(A)(1): Amount, Duration and Scope.	ACAP Agreement: Article 2.1 Service Provision, Section Q	N/A

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope and Section V.B.1. General Prior Authorization Requirements	PS&R Part II-4 Tasks, A.1, State Plan Services	CHC Agreement V(A)(1): Amount, Duration and Scope.	ACAP Agreement: Article 2.1 Service Provision, Section M	IFB #6100024102 Section M (1)(e) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Section 6 and Appendix B.
No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope	PS&R Part II-4, F, Complaint and Grievance System, Section 3.	CHC Agreement V(A)(1): Amount, Duration and Scope.	ACAP Agreement: Article 2.4 Service Authorization, Section G	IFB #6100024102 Section J(l)(4) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230, Expires 2/29/2020; CHIP State Plan Amendment (SPA) 18-0001, Section4.2.3.
Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	HealthChoices Agreement: Section II. Definitions	PS&R Appendix S; Appendix AA	CHC Agreement V(A): Covered Services. CHC Agreement V(A)(1): Amount, Duration, and Scope. CHC Agreement V(B)(1): General Prior Authorization Requirements.	ACAP Agreement: Appendix D	Sole source grant amendment 1 addressing 42 CFR 457.1230.
Specify what constitutes "medically necessary services"	HealthChoices Agreement: Section II. Definitions	PS&R HealthChoices Behavioral Health Definitions, "Medical Necessity," p. xi; Appendix T	CHC Agreement Section II Definitions.	ACAP Agreement: Article I Definitions, Section 1.33	Medical Necessity defined in CHIP Transmittal 2013-1.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	HealthChoices Agreement: Section V.B.1. General Prior Authorization Requirements	PS&R Part II-5, F, Service Access, Section 3; Primary Contractor's BH-MCO Service Authorization Policy.	CHC Agreement V(B)(1): General Prior Authorization Requirements. CHC Agreement Exhibit E: Prior Authorization Guidelines for the CHC-MCO.	ACAP Agreement: Article 2.4 Service Authorization, Section B	IFB #6100024102 Section N Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1201(i) and 457.1233(b); State Plan Amendment (SPA) 18-0001, Section 7.2.4; CHIP Procedures Handbook Sections 24.5.
Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	HealthChoices Agreement: Section V.B.1. General Prior Authorization Requirements	PS&R Appendix AA	CHC Agreement V(B)(1): General Prior Authorization Requirements. CHC Agreement Exhibit E: Prior Authorization Guidelines for the CHC-MCO.	ACAP Agreement: Article 2.4 Service Authorization, Sections A-L	IFB #6100024102 Section N Version 2/8/13; State Plan Amendment (SPA) 18-0001, Section 4.4; CHIP Procedures Handbook Chapters 1-4.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Any decision to deny or reduce services is made by an appropriate health care professional	HealthChoices Agreement: Exhibit GG Complaint, Grievance, and Fair Hearing Processes	PS&R, Part II-4, F, Complaint and Grievance System, Section 3; Appendix AA, Section C.	CHC Agreement V(B)(1): General Prior Authorization Requirements. CHC Agreement Exhibit E(B): Guidelines for Review. CHC Agreement Exhibit F(Standard II)(F): The Medical Director. CHC Agreement Exhibit F(Standard IX)(F):The CHC must ensure that Prior Authorization and Concurrent review decisions.	ACAP Agreement: Article 2.4 Service Authorization, Sections B and C	Sole source grant amendment 1 addressing 42 CFR 457.1218 and 457.1230; State Plan Amendment (SPA) 18-0001, Section 3.2
Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	HealthChoices Agreement: Section V.B.2. Time Frames for Notice of Decisions, Exhibit N(1) Standard Denial Notice-Complete Denial, Exhibit N(2) Standard Denial Notice-Partial Approval of Requested Service/Item, and Exhibit N(3) Standard Denial Notice-Approval of Different Service/Item	PS&R HealthChoices Behavioral Health Definitions, “Denial of Services,” p. viii; PS&R Part II-4 F, Complaint and Grievance System, Section 3.	CHC Agreement V(B)(2): Time Frames for Notice of Decisions. CHC Agreement Exhibit F(Standard IX)(K): providing written notification to participants of denials.	ACAP Agreement: Article 2.4 Service Authorization, Section M	Sole source grant amendment 1 addressing 42 CFR 457.1218 and 457.1230; State Plan Amendment (SPA) 18-0001, Section 7.2

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Provide for the authorization decisions and notices as set forth in §438.210(d)	HealthChoices Agreement: Section V.B. Prior Authorization of Services	PS&R Appendix AA	CHC Agreement Section V(B)(1): General Prior Authorization Requirements.	ACAP Agreement: Article 2.4 Service Authorization, Section M	State Plan Amendment (SPA) 18-0001, Sole source grant amendment 1 addressing 42 CFR 457.1218 and 457.1230; Section 7.2.4.
Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	HealthChoices Agreement: Section V.T.6. Delegated Quality Management and Utilization Management Functions	PS&R Part II-5, G, Utilization Management and Quality management, Section 3.	CHC Agreement Section V(CC)(8): Delegated Quality Management and Utilization Management Functions.	ACAP Agreement: Article 2.4 Service Authorization, Section D	Sole source grant amendment 1 addressing 42 CFR 457.1218 and 457.1230; State Plan Amendment (SPA) 18-0001, Section 3.2, Section 9.5.

Appendix C: Network Adequacy Standards

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
438.68. Time and Distance.					
Time and distance standards for specific provider types: Primary Care (adult and pediatric); OB/GYN; Behavioral Health (mental health and substance use disorder, adult and pediatric); Specialist (adult and pediatric); Hospital; Pharmacy; Pediatric Dental; Additional Provider Types	Exhibit AAA Provider Network Composition/ Service Access	Assessed by Program Evaluation Performance Summary (PEPS) reviews. Performance Substandard 1.1 for Primary Contractors Geographical Accessibility reporting. All BH contracted and credentialed providers in catchment area. Geo access maps demonstrating 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access timeframes	CHC Agreement- Exhibit T- Provider Network Composition/ Service Access	ACAP Agreement: Article 2.5 Administration, Section H	CHIP Sole Source Amendments CHIP Procedures Handbook Chapter 21
438.68. LTSS.					
Time and distance standards for LTSS provider types in which an enrollee must travel to the provider			CHC Agreement Exhibit T (1) (d)- Provider Network Composition/ Service Access		
Network adequacy standards other than time and distance standards			CHC Agreement- Exhibit T- Provider Network Composition/ Service Access		

Appendix D: Structure and Operations Standards

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
438.214. Provider Selection					
Written policies and procedures for selection and retention of providers	HealthChoices Agreement: Section V.S.1. Provider Agreements, Exhibit CCC. Physical Health MCO (PH-MCO) Provider Agreements	PS&R, II-5, F, Service Access, Section 11.	CHC Agreement Section V(BB)(2): provider agreements. CHC Agreement Exhibit U: CHC-MCO Provider Agreements.	ACAP Agreement: Article 2.5 Administration, Section H.b	IFB #6100024102 Section L Version 2/8/13; CHIP Procedures Handbook 21.11: Qualified Providers.
Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	HealthChoices Agreement: Section V.S.1. Provider Agreements, Exhibit CCC. Physical Health MCO (PH-MCO) Provider Agreements	PS&R Part II-5, E, Provider Enrollment – Credentialing/ Recredentialing.	CHC Agreement Exhibit F Standard VIII: Standards for credentialing/ Recredentialing Providers.	ACAP Agreement: Article 2.5 Administration, Section H.b	IFB #6100024102 Section C(5) Version 2/8/13
Documented process for credentialing and recredentialing that each MCO/PIHP must follow	HealthChoices Agreement: Section V.S.4. Specialists/School Based Health Centers as PCPs	PS&R Part II-5, E, Provider Enrollment – Credentialing/ Recredentialing, Section 1.	CHC Agreement Exhibit F Standard VIII relating to Standards for credentialing/ Recredentialing Providers.	ACAP Agreement: Article 2.5 Administration, Section H.b	IFB #6100024102 Section C(5) Version 2/8/13; CHIP Procedures Handbook 21.11: Qualified Providers.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	HealthChoices Agreement: Exhibit CCC. Physical Health MCO (PH-MCO) Provider Agreements, Exhibit AAA.1.p. PH-MCO Discrimination, and Exhibit II, Required Contract Terms for Administrative Subcontractors (includes general nondiscrimination provision)	PS&R Part II-5, E, Provider Enrollment – Credentialing/ Recredentialing, Section 3.	CHC Agreement Exhibit U: CHC-MCO Provider Agreements.	ACAP Agreement: Article 2.5 Administration, Section H.c	Sole source grant amendment 1 addressing 42 CFR 457.1208 and 457.1233(a); CHIP Procedures Handbook 21.11: Qualified Providers.
MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	HealthChoices Agreement: Section IV.A.A. Certification and Licensing	PS&R II-5, E, Provider Enrollment – Credentialing/ Recredentialing, Section 4; Appendix F.	CHC Agreement Section IV(A)(1): Providers.	ACAP Agreement: Article 2.5 Administration, Section H.b	IFB #6100024102 Section M(4) Version 2/8/13; State Plan Amendment (SPA) 18-0001; CHIP Procedures Handbook 21.11: Qualified Providers.
438.218. Enrollee Information.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Incorporate the requirements of § 438.10	HealthChoices Agreement: Section V.F.15. Member Handbook, Section V.G. Member Services, and Exhibit DD, PH-MCO Member Handbook	PS&R Part II-5, D, Provider Network/Relations Sections 9 and10.	CHC Agreement Section V(O)(2): CHC-Outreach Materials. Section V(O)(16): Participant Handbook. Exhibit M Participant Handbook.	ACAP Agreement: Article 4.2 Participant Handbook and Enrollment Agreement, Section B	IFB #6100024102 V Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 1207 referring to 438.10; CHIP Procedures Handbook Section 6.3 and Chapter 22.

438.224. Confidentiality.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Individually identifiable health information is disclosed in accordance with Federal privacy requirements	HealthChoices Agreement: Section V.T.8. Confidentiality, Section VII.F.4 Requests for Additional Data, and Section XIXI.D. Review of Records	PS&R Part II-3, E, Compliance with Federal and State Laws, Regulations, Department Bulletins, and Policy Clarifications.	CHC Agreement Section V(CC)(10): Confidentiality.	ACAP Agreement: Article 8.1 Holder of Data, Section A	IFB #6100024102 Agreement, Paragraph 12, Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1220 and 457.1233(e); CHIP Procedures Handbook Section 6.3.7.
438.226. Enrollment and Disenrollment.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in § 438.56	HealthChoices Agreement: Section V.F. Member Enrollment and Disenrollment	PS&R Part II-3, A, Enrollment Process; Part II-4, D, Member Services/Member Rights; Part II-4, E, Member Disenrollment.	CHC Agreement Section V(O): Participant Enrollment, Disenrollment, Outreach, and Communications.	ACAP Agreement: Article 4.4 Enrollment; Article 4.6 Disenrollment	CHIP Procedures Handbook Section 6.3.7. State Plan Amendment (SPA) 18-0001 Section 8.7.
438.228. Grievance Systems.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Grievance system meets the requirements of Part 438, Subpart F	HealthChoices Agreement: Section V.I. Member Complaint, Grievance and DHS Fair Hearing Process	PS&R Part II-4, F, Complaint and Grievance System; Appendix H	CHC Agreement Section V(R): Participant Complaint, Grievance and Fair Hearing Process. Exhibit G- Complaint, Grievance, and Fair Hearing Processes	ACAP Agreement: Appendix G Complaint, Grievance and Fair Hearing Processes	Sole source grant amendment 1 addressing 42 CFR 1260; (SPA) 18-0001 Section 7.1; CHIP Procedures Handbook Chapter 7.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	N/A	N/A	N/A	ACAP Agreement: Appendix G Complaint, Grievance and Fair Hearing Processes	Sole source grant amendment 1 addressing 42 CFR 1260; (SPA) 18-0001 Section 7.1; CHIP Procedures Handbook Chapter 7
438.230. Subcontractual Relationships and Delegation.					
Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	HealthChoices Agreement: Section V.O.222. Contracts and Subcontracts and Exhibit II, Required Contract Terms for Administrative Subcontractors	PS&R Part II-5, B, Executive Management, Section 2.	CHC Agreement Section V(X)(2): Contracts and Subcontracts.	ACAP Agreement: Article 2.5 Administration, Section G.1	IFB #6100024102 Section R(1) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1201(i) and 457.1233(b), CHIP Procedures Handbook Section 24.5.
Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	HealthChoices Agreement: Section V.O.3. Contracts and Subcontracts, Exhibit II, Required Contract Terms for Administrative Subcontractors	PS&R Part II-5, B, Executive Management, Section 3.	CHC Agreement Section V(X)(2)(b): Contracts and Subcontracts.	ACAP Agreement: Article 2.5 Administration, Sections G and H	IFB #6100024102 Section R(1) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1201(i) and 457.1233(b), CHIP Procedures Handbook Section 24.5.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Monitoring of subcontractor performance on an ongoing basis	HealthChoices Agreement: Exhibit II, Required Contract Terms for Administrative Subcontractors	PS&R Part II-5, B, Executive Management, Section 3.c.	CHC Agreement Exhibit P: Required Contract Terms for Administrative Subcontractors.	ACAP Agreement: Article 2.5 Administration, Section G.1	IFB #6100024102 Section R(1) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1201(i) and 457.1233(b), CHIP Procedures Handbook Section 24.5.
Corrective action for identified deficiencies or areas for improvement	HealthChoices Agreement: Section VIII.HHH, Sanctions Exhibit II, Required Contract Terms for Administrative Subcontractors; in addition, corrective action is noted throughout the agreement for specific areas, e.g., prior authorization	PS&R Part II-5, B, Executive Management, Section 3.d.	CHC Agreement Section VII(A)(6): Sanctions. CHC Agreement Section VII(D)(2): Sanctions. CHC Agreement Exhibit P: Required Contract Terms for Administrative Subcontractors.	ACAP Agreement: Article 2.5 Administration, Section G.h	IFB #6100024102 Section R(1) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1201(i) and 457.1233(b), CHIP Procedures Handbook Section 24.5.

Appendix E: Measurement and Improvement Standards

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
438.236. Practice Guidelines.					
Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	HealthChoices Agreement: Exhibit M(1) Quality Management and Utilization Management Program Requirements, Standard III	PS&R Part II-5, G, Utilization Management and Quality Management, Section 2.	CHC Agreement Exhibit F: Quality Management and Utilization Management Program Requirements.	ACAP Agreement: Article 2.1 Functions and Duties of the Contractor, Section Y; Article 6.1 Quality Management and Utilization Review Committee, Section B.2	IFB #6100024102 Section J(2) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1233(c).
Dissemination of practice guidelines to all providers, and upon request, to enrollees	HealthChoices Agreement: Exhibit M(1) Quality Management and Utilization Management Program Requirements, Standard III.E.	PS&R Part II-5, G, Utilization Management and Quality Management, Section 2.	CHC Agreement Exhibit F: Quality Management and Utilization Management Program Requirements.	ACAP Agreement: Article 2.1 Functions and Duties of the Contractor, Section Y	IFB #6100024102 Section J(2) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1233(c).

438.240. Quality Assessment and Performance Improvement Program.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	HealthChoices Agreement: Section V.T. QM and UM Program Requirements, Exhibit M(1) Quality Management and Utilization Management Program Requirements	PS&R Part II-5, G, Utilization Management and Quality Management, Section 3.a.	CHC Agreement Section V(CC)(2): Quality Management and Performance Improvement. CHC Agreement Exhibit F: Quality Management and Utilization Management Program Requirements.	ACAP Agreement: Article 6.1 Quality Management, Sections A, B and C; Article 6.2 Quality Management Report	IFB #6100024102 Section DD Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1240(b) and (c); (SPA) 18-0001 Section 7.1.4; CHIP Procedures Handbook Chapter 15 and Section 18.5.
Each MCO and PIHP must conduct PIPs and measure and report to the state its performance List out PIPs in the quality strategy	HealthChoices Agreement: Exhibit B(1) HealthChoices MCO Pay for Performance Program	PS&R Part II-5, G, Utilization Management and Quality Management, Section 3.b.	CHC Agreement Exhibit W: External Quality Review.	ACAP Agreement: Article 6.3 Departmental Monitoring, Section D	IFB #6100024102 Section DD Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1240(b)and (c); (SPA) 18-0001 Section 7.1.4; CHIP Procedures Handbook Chapter 15 and Section 18.5.
Each MCO and PIHP must measure and report performance measurement data as specified by the state List out performance measures in the quality strategy	HealthChoices Agreement: Exhibit M(1) Quality Management and Utilization Management Program Requirements and M(2) External Quality Review	PS&R Part II-5, G, Utilization Management and Quality Management, Section 3.b.	CHC Agreement Section V(CC) and Exhibit F: QM and UM Program Requirements.	ACAP Agreement: Article 6.3 Departmental Monitoring, Section D	CHIP Policy Manual 34.4 Performance Measures; Sole source grant amendment 1 addressing 42 CFR 457.1240(b) and (c); (SPA) 18-0001 Section 7.1.4; CHIP Procedures Handbook Chapter 15 and Section 18.5.

Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	HealthChoices Agreement: Exhibit M(1), Quality Management and Utilization Management Program Requirements	PS&R Part II-5, G, Utilization Management and Quality Management, Section 2.	CHC Agreement Section V(CC) and Exhibit F: QM and UM Program Requirements.	ACAP Agreement: Article 6.1 Quality Management, Section A.5	IFB #6100024102 Section DD Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1240(b) and (c); (SPA) 18-0001 Section 7.1.4; CHIP Procedures Handbook Chapter 15 and Section 18.5.
Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	HealthChoices Agreement: Section V.P. Special Needs Unit (SNU), Exhibit NN Special Needs Unit	PS&R Part II-5, G, Utilization Management and Quality Management, Section 2.	CHC Agreement Section V(CC) and Exhibit F: QM and UM Program Requirements.	ACAP Agreement: Article 6.1 Quality Management, Section A.5	IFB #6100024102 Section J (5) Section M (3) Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1230; CHIP State Plan Amendment (SPA) 18-0001, Section 6 and Appendix B; CHIP Procedures Handbook 15.6 and 21.26.
Annual review by the state of each quality assessment and performance improvement program If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	HealthChoices Agreement: Exhibit M(1) Quality Management and Utilization Management Program Requirements	PS&R Part II-5, G, Utilization Management and Quality Management, Section 9.	CHC Agreement Section V(CC) and Exhibit F: QM and UM Program Requirements.	ACAP Agreement: Article 6.3 Departmental Monitoring, Section A	IFB #6100024102 Section DD Version 2/8/13; Sole source grant amendment 1 addressing 42 CFR 457.1240(b) and (c); (SPA) 18-0001 Section 7.1.4; CHIP Procedures Handbook Chapter 15 and Section 18.5

438.242. Health Information Systems.					
Required Component	Physical HealthChoices	Behavioral HealthChoices	Community HealthChoices	ACAP	CHIP
Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility	HealthChoices Agreement: Section V.O.5. Management Information Systems,	PS&R Part II-7, K, In-Network Services, Section 2.	CHC Agreement Section V(CC) and Exhibit F: QM and UM Program Requirements.	ACAP Agreement: Article 2.5 Administration, Section E	IFB #6100024102 Section X Version 2/8/13; Sole source grant amendment 1 addressing timely and accurate data submissions and referring to 457.1260 and 457.1285; CHIP Procedures Manual Chapter 19.
Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	HealthChoices Agreement; Section V.F.12. Services for New Members, Section V.O.5. Management Information Systems,	PS&R Part II-7, In-Network Services, Section 2; Appendix K.	CHC Agreement Section VIII: Reporting Requirements.	ACAP Agreement: Article 10.1, Reporting Requirements, Sections B and D	IFB #6100024102 Section X Version 2/8/13; Sole source grant amendment 1 addressing timely and accurate data submissions and referring to 457.1285; CHIP Procedures Manual Chapter 19.
Each MCO and PIHP must ensure data received is accurate and complete	HealthChoices Agreement: Section V.O.5.5k. Management Information Systems	PS&R II-7, In-Network Services, Section 2; Appendix K.	CHC Agreement Section VIII(B)(1)(c) and (e), Data Completeness and Data Validation.	ACAP Agreement: Article 10.1 Reporting Requirements, Section E	Sole source grant amendment 1 addressing timely and accurate data submissions.

Appendix F: Performance Measures

Measures marked with an asterisk (*) are reported publicly and available online.

CMS Adult Core Set Measures					
Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
AMM-AD: Antidepressant Medication Management	X*		X		
AMR-AD: Asthma Medication Ratio Ages 19- 64	X*		X		
BCS-AD: Breast Cancer Screening	X*		X		
CBP-AD: Controlling High Blood Pressure	X*		X		
CCP-AD: Contraceptive Care – Postpartum Women Ages 21-44	X*				
CCS-AD: Cervical Cancer Screening	X*		X		
CCW-AD: Contraceptive Care – All Women Ages 21-44	X*				
CHL-AD: Chlamydia Screening on Women Age 21-44	X*				
COB-AD: Current Use of Opioids and Benzodiazepines	X*		X		
CPA-AD: Consumer Assessment of Healthcare Providers and Systems, Health Plan Survey, Version 5.0	X*		X	X*	
FUA-AD: Follow-Up After Emergency Department Visit for Mental Health or Alcohol and Other Drug Dependence - (BH enhanced)	X	X			
FUH-AD: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older - (BH Only)		X	X		
FUH-AD: Follow-Up After Hospitalization for Mental Illness: Age 6 or Older- (BH only)		X*			
FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness – (BH enhanced)	X				
FVA-AD: Flu Vaccinations for Adults Age 18 to 64	X*		X		
HCBS CAHPS			X		
HPC-AD: HbA1c: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	X*				
HPCMI-AD: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) – (BH-enhanced)	X				
IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X*	X*			
MSC-AD: Medical Assistance with Smoking and Tobacco Use Cessation	X*		X		
OHD-AD: Use of Opioids at High Doses (UOD)	X*				
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder [2020 1st year measure]	X				
PC 01-AD: Elective Delivery	X*				

Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
PCR-AD: Plan All-Cause Readmissions	X*		X		
PPC-AD: Postpartum Care	X*				
PQI 01-AD: Diabetes Short-Term Complications Admissions Rate (DAR)	X*				
PQI 05-AD: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	X*				
PQI 08-AD: Heart Failure Admission Rate	X*				
PQI 15-AD: Asthma in Younger Adults Admission Rate (AAR)	X*				
SAA-AD: Adherence to Antipsychotics for Individuals with Schizophrenia (BH enhanced)	X*	X	X		
SSD-AD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	X*	X	X		

CMS Child Core Set Measures					
Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
ADD-CH: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (BH enhanced)	X*			X*	
AMB-CH: Ambulatory Care – Emergency Department (ED) Visits	X*			X*	
AMR-CH: Asthma Medication Ratio: Ages 5- 18	X*			X*	
APM-CH: Metabolic Monitoring for Children and Adolescents on Antipsychotics	X*			X*	
APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents	X	X for 2023		X*	
CCP-CH: Contraceptive Care – Postpartum Women Ages 15-20	X*			X*	
CCW-CH: Contraceptive Care – All Women Ages 15-20	X*			X*	
CHL-CH: Chlamydia Screening in Women Ages 16-20	X*			X*	
CIS-CH: Childhood Immunization Status	X*			X*	
CPC-CH: Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0 (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	X*			X*	
DEV-CH: Developmental Screening in the First Three Years of Life	X*			X*	
FUH-CH: Follow-Up After Hospitalization for Mental Illness: Ages 6-17- (BH only)		X*		X*	
IMA-CH: Immunization for Adolescents	X*			X*	
LBW-CH: Percentage of Live Births Weighing Less Than 2,500 Gram	X*				
PC 02-CH: Cesarean Section for Nulliparous Vertex (PC02)	X*			X*	
PDENT-CH: Percent of Eligibles Who Received Preventive Dental Services	X			X*	
PPC-CH: Prenatal and Postpartum Care: Timeliness of Prenatal Care	X*				
SRM-CH: Sealant Recipient on Permanent Molars [2021 1st year measure]	X				
W30-CH: Well-Child Visits in the First 30 Months of Life [2021 1st year measures]	X			X*	
WCV-CH: Child and Adolescent Well-Care Visits [2021 1st year measures]	X			X*	
WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents	X*			X*	

CMS Behavioral Health Core Set Measures					
Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	X*	X for 2023		X*	
ADD-CH: Follow-Up Care for Children Prescribed ADHD Medication (30d/270d)	X*			X*	
AMM-AD: Antidepressant Medication Management Acute phase	X*		X		
APM-CH: Metabolic Monitoring for Children and Adolescents on	X*				
COB-AD: Concurrent Use of Opioids and Benzodiazepines	X*				
FUA-AD: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – (BH enhanced)	X	X			
FUH-CH: Follow-Up After Hospitalization for Mental Illness: Ages 6-17 (7d and 30d) – (BH only)		X*	X	X*	
FUH-AD: Follow-Up After Hospitalization for Mental Illness: Ages 18 and older (7d and 30d) – (BH only)		X*	X		
FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness – (BH enhanced)	X	X			
HPCMI-AD: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) – (BH enhanced)	X	X			
IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (13 and older)	X*	X*			
MSC-AD: Medical Assistance with Smoking and Tobacco Use Cessation	X*				
OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer rate per 1000 members	X*				
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder [2020 1st year measure]	X				
SAA-AD: Adherence to Antipsychotics for Individuals with Schizophrenia	X*	X			
CDF-CH: Screening for Clinical Depression and Follow-Up Plan (Ages 12-17)	Piloted 2021, reported 2022			Optional*	
CDF-AD: Screening for Clinical Depression and Follow-Up Plan (Ages	-				
SSD-AD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – (BH enhanced)	X*	X for 2021	X		

HEDIS® Measures					
Measure Description	OM	OMHSAS	OLTL	CHIP	ACAP
AAB: Avoidance of Antibiotic Treatment With Acute Bronchitis/Bronchiolitis (Inverted low rate measure)	X*		X		
AAP: Adult Access to Preventive/Ambulatory Health Services	X*		X		
ABX: Antibiotic Utilization – Percentage of antibiotics of concern of Total Antibiotic Prescriptions – Total	X*		X		
ADD-E: Follow-up care for Children Prescribed ADHD Medication [2020 1st year measure]	X			Optional *	
ADV: Annual Dental Visit	X*			X*	
AIS-E: Adult Immunization status [2020 1st year measure]	X		X		
AMB: Ambulatory Care – Emergency Department (ED) Visits	X*		X		
ART: Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	X*		X		
BCS-E: Breast Cancer Screening [1st year measure]	X		X		
CAU: LTSS Comprehensive Assessment and Update			X		
CDC: Comprehensive Diabetes Care • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • Blood pressure control (<140/90 mm Hg)	X*		X		
COA: Care for Older Adults			X		
COU: Risk of Continued Opioid use	X*		X		
CPU: LTSS Comprehensive Care Plan and			X		
CRE: Cardiac Rehabilitation [1st year measure]	X				
CWP: Appropriate Testing for Pharyngitis	X*			X	
DRR-E: Depression Remission or Response for Adolescents and Adults (Ages 12-17)				Optional *	
DSF-E: Depression Screening and Follow-up for Adolescents and Adults				Optional*	

Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
FSP: Frequency of Selected Procedures • Bariatric Weight Loss Surgery • Tonsillectomy • Hysterectomy (Abdominal/Vaginal) • Cholecystectomy (Open/Laparoscopic) • Back Surgery • Mastectomy • Lumpectomy	X*		X		
HDO: Use of Opioids at High Dosage			X		
IAD: Identification of Alcohol and Other Drug Services				X	
IPU: Inpatient Utilization: General Hospital/Acute Care	X*		X	X	
KED: Kidney Health Evaluation for Patients with Diabetes [1st year measure]	X				
LBP: Use of Imaging Studies for Low Back Pain (Inverted low rate measure)	X*		X		
LSC: Lead Screening in Children	X*			X*	
MPT: Mental Health Utilization				X*	
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females	X*				
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	X*		X		
PCE: Pharmacotherapy Management of COPD Exacerbation	X*		X		
PCR: Plan All Cause Readmission	X*		X		
PDS-E: Postpartum Depression Screening and Follow-Up [1st year measure]	X				
PND-E: Prenatal Depression Screening and Follow-Up [1st year measure]	X				
POD: Pharmacotherapy for Opioid Use Disorder (Ages 16-19)	X*		X		
PRS-E: Prenatal Immunization status	X				
RAC: LTSS Reassessment/Care Plan Update after Inpatient Discharge			X		
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	X*		X		
SCP: LTSS Shared Care Plan			X		
SMC: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	X*	X	X		
SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia	X*		X		
SPC: Statin Therapy for Patients with Cardiovascular Disease	X*		X		
SPD: Statin Therapy for Patients with Diabetes	X*		X		

Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	X*		X		
SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Anti-Psychotic Medications	X*	X	X		
TRC: Transitions of Care			X		
UOP: Use of Opioids from Multiple Providers	X*		X		
URI: Appropriate Treatment for Upper Respiratory Infection	X*			X*	

Pennsylvania Performance Measures					
Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
AAR: Asthma in Younger Adults Admission Rate	X*				
ADD: Annual Dental Visits for Enrollees with Developmental Disabilities	X*				
Annual Number of Asthma Patients with One or More Asthma Related ER Visits				X*	
ADHD: Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication, BH Enhanced	X*				
A-ADV: Adult Annual Dental Visit ≥ 21	X*		X		
AMM: Antidepressant Medication Management			X		
Birth File • **NSV** Cesarean Rate for Nulliparous Singleton Vertex • **ED** (BIRTH FILE) Elective Delivery • **LBW** Percentage of Live Births Weighing Less than 2,500 Grams	X*				
CAU: LTSS Comprehensive Assessment and Update			X		
CCP: Contraceptive Care Postpartum Women	X*			X*	
CCW: Contraceptive Care All Women	X*			X*	
COB: Concurrent Use of Opioids and Benzodiazepines	X*				
COPD: Chronic Obstruction Pulmonary Disease Admission Rate (Asthma in Older Adults Admission Rate)	X*				
CPU: CPU: LTSS Comprehensive Care Plan and Update			X		
DAR: Diabetes Short-Term Complications Admission Rate	X*				
DEV-CH: Developmental Screening first three years of Life	X*			X*	
HF: Heart Failure Admission Rate	X*				
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder	X*				
PAS: Access to Personal Assistance Services			X		

Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
PDS: Perinatal Depression Screening • Screening for depression during prenatal visit: Use of validated depression screening tool • Screening for depression during postpartum visit: Use of validated depression screening tool • Screened positive for depression during prenatal visit: Further evaluation/treatment if screened	X*				
PSS: Prenatal Screening for Smoking • Screening for smoking and treatment discussion • Counseling/advice for smokers • Prenatal screening for environmental tobacco exposure • Counseling/advice for environmental tobacco exposure • Smokers who quit during their pregnancy	X*				
PA-Specific Follow-up after Hospitalization for Mental Illness 7 d/30 d		X			
RAC: LTSS Reassessment/Care Plan Update after Inpatient			X		
Readmission within 30 days of an Inpatient Psychiatric Discharge		X	X		
SAA-AD: Adherence to Antipsychotics for Individuals with Schizophrenia (Adult Core Set MAC-Pro)	X*	X	X		
SCP: LTSS Shared Care Plan			X		
SEAL-CH: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk				X*	

ACAP Measures					
Measure Description	OMAP	OMHSAS	OLTL	CHIP	ACAP
Episodes of: • Law enforcement involvement • Psychiatric emergency room care • Psychiatric inpatient hospitalization • Crisis incidents • Mental health crisis interventions					X
Percentage of Participants with jobs or engaging in volunteer work					X
Number of hours Participants work or are engaged in volunteer work					X
Initial visit with a PCP within 3 weeks of enrollment					X
Diabetes management					X
Annual gynecological exams					X
Measures of Participants' independence and social skills					X
Measures of Participants' parental satisfaction and quality of life					X
Measures of Participants' quality of life					X

Appendix G: Current Initiatives

Initiative Name	Description	Beginning Date	Associated Goals	Outcomes Tracked
Opioid Use Disorder Centers of Excellence	A hub-and-spoke model focused on increasing access to MAT, integrating physical and behavioral health, and using community-based care management teams to provide recovery support services. Previously grant funded, these providers began billing Medicaid MCOs in 2019 and receive a per-member-per-month bundled payment. DHS is exploring value-based payment arrangements for these providers.	October 2016	Access Quality Cost	• Continued engagement in treatment and recovery • Adherence to Medication Assisted Treatment • Receipt of primary care and ambulatory behavioral health services • Administration of social determinants of health screenings • Overdose Rates
Medicaid Home Visiting	Physical Health MCOs are required to cover additional home visits for first-time and at-risk mothers using evidence-informed home visiting models to address clinical and non-clinical (including developmental) needs of infants and their families.	January 2020	Access Quality	• Number of families who receive home visits • Number of visits per family • Provision of all necessary prenatal and postpartum screenings • Child development benchmarks
Pediatric Shift Nursing	DHS convened a multi-disciplinary work group to make recommendations to address gaps in the delivery of pediatric shift nursing services.	June 2019	Access	• Number of authorized hours of pediatric shift nursing services in home settings that were not staffed

Initiative Name	Description	Beginning Date	Associated Goals	Outcomes Tracked
Resource and Referral Tool	DHS will procure a platform that will allow human services agencies to make, receive, and track referrals to ensure that all Pennsylvanians are connected to the services they need.	January 2019	Access	• Number of resources listed in tool • Number of organizations registered to use tool • Number of referrals made • Number of referrals completed
Perinatal Quality Collaborative	This group is a multi-disciplinary coalition of maternity care teams, payers, and stakeholders focused on using data collection and policy recommendation to improve maternal health. The group's purpose is to identify regional gaps in care to tailor quality targets, identify best practices to improve quality of care for mom and baby, implement plans to fill the identified gaps and implement best practices, and track progress through data collection.	April 2019	Access Quality Cost	• Maternal mortality and morbidity • Infant mortality and morbidity • Prenatal visits • Postpartum visits • Well child visits • Rates of Neonatal Abstinence Syndrome • Rates of maternal depression screenings
Suicide Prevention Task Force	The Task Force includes participants from many state agencies and stakeholder groups. The Task Force will develop Pennsylvania's statewide suicide prevention plan, which is a four-year strategy to reduce suicide in Pennsylvania and fight stigma associated with suicide, suicide attempts, and mental health services.	May 2019	Access	• Deaths by suicide • Lifeline calls and text messages • Utilization of mental health services

Initiative Name	Description	Beginning Date	Associated Goals	Outcomes Tracked
Integrated Community Wellness Centers	Modeled after the Certified Community Behavioral Health Clinic Demonstration (CCBHC) funded by SAMHSA, there are six providers (seven sites) that receive a monthly prospective payment service rate for providing nine core services that promote integrated physical and behavioral healthcare for patients. Using quality performance and outcome measures, the Department will identify best practices for scalability, sustainability and expansion of the model.	January 2020	Access	HEDIS® measures related to time to initial evaluation, certain preventive and screening services, suicide risk assessments, screening for clinical depression, weight assessments for children, and depression remission at 12 months
Vulnerable Populations	By Executive Order, the Governor outlined the Administration's commitment to protecting vulnerable populations and created an Office of Advocacy and Reform to coordinate the implementation of the Executive Order. ODP, OMHSAS and OLTL are examining program changes to improve protections for older Pennsylvanians, children and people with disabilities.	July 2019	Quality	• Older Adult Protective Services findings • Child Protective Services findings • General Protective Services findings
Hospital Quality Improvement Programs	Incentive payments are provided to hospitals which achieve incremental improvement benchmarks or implement certain processes. Two improvement programs are currently in operation: one to decrease potentially preventable admissions, and another to facilitate connection to addiction treatment services within seven days of an overdose-related emergency department visit.	January 2019	Quality Cost	• Number of preventable admission events by acute care hospitals • Implementation of clinical pathways: Induction of buprenorphine in the ED; Warm Hand-Off to treatment provider; Serving pregnant women with Opioid Use Disorder; Inpatient admission for MAT induction