COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Dear Members:

As chair of the Patient-Centered Medical Home Advisory Council, I am pleased to submit the comprehensive accounting of progress made in 2019 by the Patient-Centered Medical Home Advisory Council as required by Act 198 of 2014. The Council's ideas, contributions, and enthusiasm in recommending effective advancements and innovations to the Patient-Centered Medical Home model are both valuable and inspiring.

I would like to thank the members of the General Assembly for their interest in enhancing the quality of care for Medicaid beneficiaries in our Commonwealth.

In addition to the Patient-Centered Medical Home Advisory Council's 2019 report, a roster of the appointed Council members is enclosed for your records.

Sincerely,

Teresa D. Miller
Secretary

OFFICE OF THE SECRETARY

P.O. BOX 2675, HARRISBURG, PA 17105 | 717.787.2600/3600 FAX:717.772.2062 | www.dhs.pa.gov

Patient-Centered Medical Home 2019 Advisory Council Report

A. Introduction to Patient-Centered Medical Homes

Pennsylvania's Patient-Centered Medical Home (PCMH) Advisory Council was established by Act 198 of 2014 to advise the Department of Human Services (DHS) on how Pennsylvania's Medicaid program can increase the quality of care while containing costs through the following PCMH model approaches:

1. Coordinate and provide access to evidence-based health care services, emphasizing convenient, comprehensive primary care and including preventive, screening, and well-child health services.
2. Provide access to appropriate specialty care, mental health services, inpatient services, and any evidence-based alternative therapies.
3. Provide quality-driven and cost-effective health care.
4. Provide access to medication and medication therapy management services, in accordance with section 935(c) of the Patient Protection and Affordable Care Act (Public Law 111-148, 42 U.S.C. § 299b-35(c)).
5. Promote strong and effective medical management, including, but not limited to, planning treatment strategies, monitoring health outcomes and resource use, sharing information and organizing care to avoid duplication of services, including the use of electronic medical records (EMR). In sharing information, the protection of the privacy of individuals and of the individuals' information shall be priorities. In addition to any and all other federal and state provisions for the confidentiality of health care information, any information-sharing required by a medical home system shall be subject to written consent of the patient.
6. Provide comprehensive care management to patients to align and assist with treatment strategies, health outcomes, resource utilization and organization of care, and address determinants of health impeding goals of care.
7. Emphasize patient and provider accountability.
8. Prioritize access to the continuum of health care services in the most appropriate setting and in the most cost-effective manner.
9. Establish a baseline for medical home goals and establish performance measures that indicate a patient has an established and effective medical home. These goals and performance measures may include, but need not be limited to, childhood immunization rates, well-child care utilization rates, care management for chronic illnesses, cancer prevention services, and emergency room utilization.

The PCMH Advisory Council established the parameters and listed the components of a PCMH program for Medicaid beneficiaries. The recommendations of the Council were:

1. Integrate physical health (PH) and behavioral health (BH) within the PCMH.
2. Measure individual and family satisfaction within the PCMH.
3. Develop Health Homes for persons with persistent serious mental illness (PSMI), substance use disorder (SUD), children with serious emotional disturbance (SED), and patients with two or more complex medical conditions.
4. Further develop Medication Therapy Management (MTM).
5. Continue to implement Telemedicine, Health Information Technology (HIT), and Health Information Exchange (HIE).

6. Define quality metrics and cost data for the PCMH and Health Homes programs.
7. Continue workforce development.
8. Develop alternative payment models.

DHS implemented programs and initiatives based on these recommendations. This report will highlight progress of these initiatives and programs.

As reported in 2017, DHS's Office of Medical Assistance Programs (OMAP) implemented the components of a PCMH program, as established by the Council, and recommendations 2, 6, and 8 through the Physical Health HealthChoices Managed Care Organization (PH-MCO) contract. All PH-MCOs have implemented an MTM program, recommendation 4, as described in Section E of this report. DHS' Office of Mental Health and Substance Abuse Services (OMHSAS) implemented recommendations 3, 6, and 8 through the development of Certified Community Behavioral Health Clinics (CCBHCs). OMAP and OMHSAS jointly implemented portions of recommendations 3, 6, and 8 by developing the Centers of Excellence (COE) program to treat those with opioid use disorder (OUD). OMAP and OMHSAS also implemented recommendation 1 through the use of Integrated Care Plans (ICPs) to encourage whole-person care. Both OMAP and OMHSAS continue to develop or enhance existing programs to address recommendations 5 and 7. This report will provide detailed updates on the progress DHS has made through the following initiatives: The OUD-COEs, PCMHs, CCBHCs, MTM, and Telemedicine.

B. Opioid Use Disorder Centers of Excellence

As reported in 2017, the Commonwealth has shown progress in fighting the epidemic through multiple initiatives which include: growing treatment access through Medicaid expansion, increasing access to medication assisted treatment (MAT), expanding opioid education and training for health professionals, establishing a Naloxone standing order, and opening a 24-hour help line that connects people to treatment. Pennsylvania averages 18 opioid-related deaths per day. This is an increase from the last report in 2017 when Pennsylvania averaged 13 opioid-related deaths per day. Maintaining a sense of urgency and placing a strong emphasis on continued concerted efforts to combat the opioid crisis remains a top priority.

The OUD-COEs were introduced by Governor Tom Wolf in 2016 when he declared the opioid epidemic a top administration priority. The OUD-COEs generated immediate, strong interest among the public and providers alike. The announcement of a call for applications for the OUD-COE program yielded 116 applications from providers across the commonwealth. To date, there are 45 OUD-COEs across 27 counties that began with a staggered implementation approach in October 2016 and ended with the final OUD-COE going live in May 2017. The COE program is intended to transform the OUD service delivery system into team-based treatment, whole-person focused care addressing both BH and PH concerns as well as providing assistance in the navigation of care so patients stay engaged in their treatment. The care teams at COEs consist primarily of peer recovery specialists, nurses, and social workers.

DHS is monitoring these outcomes on a monthly basis. When DHS identifies areas in which connections to treatment or needed services are not meeting previous levels for a provider, the provider receives one-on-one technical assistance to ensure prompt and complete referrals. As of February 28, 2019, DHS has seen the following positive results from COE efforts:

1. 21,938 individuals with OUD have been touched by the COEs.
2. 19,688 individuals have had a level of care assessment completed by the COEs.

3. 18,760 individuals have initiated treatment for OUD.
4. The average duration of ongoing treatment engagement is 90 days.
5. Of those starting OUD treatment, 82 percent have been referred for drug and alcohol counseling and 73 percent have received counseling services.
6. Of those starting OUD treatment, 43 percent have been referred for treatment of a co-occurring mental health (MH) condition.
7. Over 68 percent of those referred for a MH condition received a MH service.

Prior to the introduction of COEs, as few as 48 percent of Medicaid beneficiaries diagnosed with OUD were receiving treatment. Of those receiving treatment, only 33 percent continued treatment for more than 30 days. Today, more than 70 percent receive treatment after being diagnosed with OUD and 62 percent remain in treatment for more than 30 days.

On January 1, 2019, PH COEs began billing PH-MCOs for care management services. BH COEs began billing BH-MCOs for care management services on July 1, 2019. This represents a movement from grant funding to a more sustainable model of funding COE activities. DHS has developed a per-member-per month (PMPM) rate for each COE patient. The COE is paid this amount if it provided care management services to a member during that calendar month.

Additional information about the COEs can be obtained at the following web site: https://www.dhs.pa.gov/Services/Assistance/Pages/Centers-of-Excellence.aspx.

C. Patient-Centered Medical Homes

The concept of a medical home was presented by the American Academy of Pediatrics (AAP) in 1967 as a primary care model described as "accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective."[1] Both the World Health Organization and the Institute of Medicine adopted the model. By 2002 the Chronic Care Model was introduced by Dr. Edward H. Wagner of the Kaiser Permanente Washington Health Research Institute as a precursor to today's PCMH model and is defined as "an evidence-based framework for health care that delivers safe, effective, and collaborative care to patients"[2] and is commonly acknowledged for its ability to lead health care teams in the treatment and care for chronically ill patients and is promoted as an established technique to improve chronic health care.

DHS leveraged the work of the Advisory Council to set parameters for the PH-MCO adoption of PCMHs with the objective of an improved care model. The PCMH model delivers inclusive primary care for children, youth, and adults in a health care environment that facilitates partnerships between patients and their provider and the patient's family and others when appropriate. Patient care in the PCMH model focuses on the whole person, taking both the individual's PH and BH into account. Patient care is comprehensive, inclusive, and team-based and highlights whole person orientation through appropriately arranging care with other qualified professionals and coordinating care through all stages of life: acute care, chronic care, preventive services, and end of life care. The PCMH model is supported by: EMR, HIE, virtual telemedicine services, and patient registries as well as personal connections through community-based, peer-driven support services. PCMHs must meet certain recognition or certification standards and quality measures. In return, it is expected PCMHs be fairly compensated for

[1] https://www.pcpcc.org/content/history-0

[2] https://www.kpwashingtonresearch.org/our-research/our-scientists/wagner-edward-h/

the cost of providing care through fee-for-service payments, through per member per month payments and through value-based purchasing agreements with the PH-MCOs.

Based on the above principles and recommendations from the PCMH Council, OMAP required PH-MCOs to identify PCMHs to serve some of their members. The 2019 HealthChoices agreements require that PH-MCOs identify and fund PCMHs that serve at least 20 percent of their total membership and at least 33 percent of members that fall within the top 5th percentile of medical costs. Exhibit DDD of the HealthChoices Agreement outlines PCMH program requirements. The requirements include:

1. The PH-MCOs are required to make monthly payments to each PCMH based on factors such as clinical complexity, age, medical costs, and composition of the care management team.
2. Collect key quality metrics.
3. Reward PCMH providers with quality-based enhanced payments focusing on key performance measures defined by the department.
4. Develop quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and MCOs in a HealthChoices region.
5. Provide timely and actionable data to PCMHs.
6. Report annually on the clinical and financial outcomes of their PCMH program.

PH-MCOs must use specific criteria to select the PCMHs within their networks. Providers and practices must meet the following requirements for the PH-MCO to consider them eligible to participate in the PCMH program.

1. Be identified as a high-volume Medicaid practice already participating in the PH-MCO provider pay for performance (P4P) program or a defined set of practices willing to share care management resources.
2. Accept all new patients or be open for face-to-face visits at least 45 hours per week.
3. Have already received a payment in the Medicaid or Medicare electronic health record (EHR) meaningful use program.
4. Join a HIE for the sharing of health-related data.
5. Deploy a Community Based Care Management (CBCM) team.
6. Collect and report annual quality data and outcomes pertinent to their patient population as defined by the current PH-MCO provider P4P program, the Integrated Care Program (ICP), and additional population specific measures defined by DHS.
7. Conduct internal clinical quality data reviews on a quarterly basis, report results, and discuss improvement strategies with the PH-MCO.
8. Measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience.
9. Include as part of the health care team patient advocates or family members to support the patient's health goals and advise practices.
10. See 75 percent of patients within 7 days of discharge from the hospital with an ambulatory sensitive condition.
11. Participate in a PCMH learning network.
12. Complete a Social Determinants of Health assessment using a Nationally-recognized tool and submit ICD-10 diagnostic codes for all patients.
13. Educate and disclose to patients through low-literacy appropriate material the practice is a PCMH that has a community-based care management team available to help patients manage complex care needs.

The PCMHs are focused on the same quality metrics included in the provider P4P program listed below:

1. Controlling High Blood Pressure
2. Diabetes: HbA1c Poorly Controlled
3. Medication Management for People with Asthma 75 Percent
4. Annual Dental Visit (Ages 2 – 20 years)
5. Well Child Visits, First 15 Months of Life (6 or More Visits)
6. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
7. Adolescent Well-Care Visits
8. Reducing Potentially Preventable Readmissions
9. Ambulatory Care: Emergency Department visits
10. Prenatal Care in the First Trimester
11. Postpartum Care
12. Frequency of Ongoing Prenatal Care >81%

The PH-MCOs must submit electronic submission of quality measures and report on their PCMH progress through the submittal of an annual report with quarterly updates. These mechanisms allow DHS to gauge the progress of initiatives as well as their effectiveness.

Data available as of March 31, 2019 shows that the PH-MCOs have identified approximately 1,111 unique high-volume practices as PCMHs and $6,499,385 was paid to these practices in the first quarter of 2019. In the first quarter of 2019, these identified PCMHs served approximately 651,733 members with 29,354 members falling in the top 5th percentile of medical costs. In addition, the PCMHs are serving approximately 78,774 members with a diagnosis of PSMI. Regional face-to-face and webinar Learning Network meetings have been occurring since July 2017.

Listed below are the HealthChoices PH-MCOs and the number of PCMH practices they have identified (as of March 31, 2019). Please note that some of these PCMH practices serve more than one PH-MCO and therefore some are duplicated in the counts below.

1. Aetna Better Health: 399
2. AmeriHealth Caritas Northeast: 28
3. AmeriHealth Caritas Pennsylvania: 0
4. Gateway Health Plan, Inc.: 322
5. Geisinger Health Plan: 108
6. Health Partners Plans: 79
7. Keystone First Health Plan: 67
8. UnitedHealthcare Community Plan: 145
9. UPMC for You, Inc.: 268

D. Certified Community Behavioral Health Clinics

CCBHCs ensure access to high-quality, community-based behavioral health care. CCBHCs were introduced on April 1, 2014, when the Protecting Access to Medicare Act of 2014, Pub. L. 113-93 (PAMA) was signed into law. The PAMA included a provision that authorized a CCBHC Demonstration program separated into two parts. This law infused $1.1 billion into community-based health services for Medicaid patients. The Commonwealth, through OMHSAS, was one of eight states that received a CCBHC Phase 1 Demonstration grant in December 2016 from the

Substance Abuse and Mental Health Services Administration (SAMHSA). CCBHCs provide patients with access to an extensive selection of quality services at one location as well as eliminate the obstacles that traditionally exist across physical and behavioral health systems. The CCBHCs primarily serve adults and children with serious mental illnesses and substance abuse disorders. The increase in coordination and individualized care that the CCBHCs provide have the potential to greatly improve the quality of life for those they assist throughout many facets of their lives.

The objective of the CCBHC application process was to assess and select eligible community behavioral health providers who met or strongly demonstrated the future ability to meet all certification criteria established under the federal CCBHC planning grant and program demonstration initiative.

Agencies selected for the CCBHC certification process were expected to develop outpatient networks of primary care, mental health, and substance use providers serving all ages, as well as to adopt a common set of tools, approaches, and organizational commitments to treat individuals in a seamless and integrated fashion.

It is expected that the CCBHCs provide certain fundamental services to patients. These services include:

1. Crisis services.
2. Targeted case management.
3. Outpatient MH and substance use services.
4. Patient-centered treatment planning.
5. Mental health screening, assessment, and diagnosis.
6. Psychiatric rehabilitation services.
7. Peer and family support.
8. Care for veterans and members of the military.
9. Mental health outpatient primary care screening and monitoring.

DHS's final selection of CCBHCs includes seven outpatient clinic sites, comprised of both rural and urban locations throughout the Commonwealth:

1. Berks Counseling Center, Berks County
2. Cen Clear Child Services, Clearfield County
3. Cen Clear Child Services, Jefferson County
4. Northeast Treatment Centers, Philadelphia County
5. Pittsburgh Mercy, Allegheny County
6. Resources for Human Development, Montgomery County
7. The Guidance Center, McKean County

The CCBHCs must track and submit quality measures to the Commonwealth no later than nine months after the first Demonstration Year (DY) is over. DY 1 is defined as July 1, 2017 to June 30, 2018 and DY 2 is defined as July 1, 2018 to June 30, 2019. The Commonwealth measure results are provided to SAMHSA no later than 15 months after the DY is over. There are nine CCBHC measures and 13 state level measures. DY 1 data is not available at the time of this report. OMHSAS is currently analyzing the results as compared to national and state benchmarks. The results for DY2 will not be available until after 7/31/20.

CCBHC performance measures:

1. Time to Initial Evaluation (I-EVAL)
2. Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)
3. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
4. Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
5. Screening for Clinical Depression and Follow-Up Plan (CDF-BH)
6. Weight Assessment for Children/Adolescent: Body Mass Index Assessment for Children/ Adolescents (WCC-BH)
7. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
8. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
9. Depression Remission at Twelve Months (DEP-REM-12)

State level performance measures:

1. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication (SSD)
2. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
3. Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH) Initiation phase Maintenance Phase
4. Antidepressant Medication Management (AMM-BH) Acute phase Maintenance phase

5. Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET- BH) Initiation phase (ages 13-17) Initiation phase (ages 18-64) Engagement phase (ages 13-17) Engagement phase (ages 18-64)
6. Plan All -Cause Readmission Rate (PCR-BH)
7. Follow-Up After Discharge from the Emergency Department for Mental Health Treatment (FUM) ED visits with 7-day follow-up ED visits with 30-day follow-up
8. Follow-Up After Discharge from the Emergency Department (FUA) ED visits with 7-day follow-up ED visits with 30-day follow-up
9. Follow-Up After Hospitalization for Mental Illness (Adult) (FUH-BH-A) 7-day follow-up 30-day follow-up
10. Follow-Up After Hospitalization for Mental Illness (Child) (FUH-BH-C) 7-day follow-up 30-day follow-up
11. Housing Status (HOU)
12. Patient Experience of Care Survey (PEC Adults)
13. Youth/Family Experience of Care Survey (Y-FEC)

In addition to the measures above, Pennsylvania will compute results for six Quality Bonus Payment (QBP) measures compared to their baseline (pre-demonstration) results. The QBP measures comprise of four state measures and two CCBHC measures. These results are not available at the time of this report as baselines are currently being calculated.

In November 2019, the federal government signed into law H.R. 3055, the Further Continuing Appropriations Act 2020 and Further Health Extenders Act of 2019 (Pub. L. 116-69), extending the CCBHC federal demonstration through 12-20-19. DHS is currently reviewing the financial impact and outcomes data of the Demonstration to determine how to support the CCBHC model moving forward.

Additional information about the CCBHC program can be found at the following web link: https://www.dhs.pa.gov/providers/Providers/Pages/CCBHC.aspx.

E. Medication Therapy Management (MTM)

The HealthChoices PH-MCOs emphasize the importance and implementation of the care delivery services of MTM. Many Medicaid patients take a wide variety of medication for various health concerns or chronic diseases and it is essential that their medication usage be closely monitored to ensure the best possible care and outcomes. MTM provides patients with many benefits and affords them invaluable information that is crucial to their health and well-being. The definition of MTM by the American Pharmacists Association is extensive and is as follows: "Medication therapy management is a service or group of services that optimize therapeutic outcomes for individual patients. Medication therapy management services include medication therapy reviews, pharmacotherapy consults, anticoagulation management, immunizations, health and wellness programs, and many other clinical services. Pharmacists provide medication therapy management to help patients get the best benefits from their medications by actively managing drug therapy and by identifying, preventing, and resolving medication-related problems."[3]

The DHS focus for this initiative is on medication adherence for diabetes, hypertension, asthma, HIV, Hepatitis C, and antipsychotic medications. While improving medication adherence for these conditions is an essential role of MTM, DHS expects the PH-MCOs to help implement MTM across populations with other conditions. All PH-MCOs have implemented an MTM program, described below.

Aetna Better Health implemented a Community Health Worker (CHW) initiative with MTM in mind. Part of the CHW's duties will include improving medication adherence in the adult population with SPMI.

AmeriHealth Caritas has two concurrent MTM programs that continued into 2019. Their Retail Pharmacy and Outcomes MTM programs continue to provide members with retail-level MTM services since their introduction in September 2015. The programs are designed to assist members through adherence check-ins, consultations, and drug safety reviews at their local pharmacy. Through the third quarter of 2018, 2,330 members had been engaged by the AmeriHealth Caritas's MTM programs.

Gateway has implemented a variety of MTM programs. The first involves embedded pharmacists in select primary care provider offices. These pharmacy care managers promote medication adherence through face-to-face consultations with members. Gateway has also partnered with the Pennsylvania Pharmacist Care Network (PPCN), a network of Pennsylvania pharmacists who receive from Gateway a list of members who may be at risk for non-adherence. Pharmacists who belong to PPCN then counsel members on medication adherence when the member is in a participating pharmacy. Gateway also collaborates with two vendors who provide multi-dose medication packaging along with monthly medication reconciliation. Medications are shipped directly to the member's home and interventions are conducted either in the home or telephonically. Finally, starting in March of 2019, Gateway has partnered with the Pharmacy Physicians Alliance, which provides for a CHW to perform a medication reconciliation in the member's home. Medications are then delivered to the member and monthly calls are made to promote compliance.

[3] https://pharmacistsprovidecare.com/mtm

Geisinger Health Plan Family uses the strength of the Geisinger Ambulatory Clinical Pharmacists program to optimize its MTM program. The Ambulatory Clinical Pharmacists program employs 69 full-time clinical pharmacists located in 49 Geisinger ambulatory clinics, that can provide face-to-face consultations with members to promote medication adherence, help the member manage chronic conditions, and address gaps in care.

Health Partners Plans employs one in-house pharmacist to provide pharmacy support with the goal of providing consultative services related to medication adherence and reconciliation, which may include attendance at practice rounds and physician and member consultation and training related to pharmaceuticals. Health Partners Plans also works directly with pharmacists in its network to promote adherence.

Keystone First has an MTM contract with Outcomes MTM that is designed to improve collaboration among pharmacists, prescribers, and other health care professions as well as to enhance communication between patients and their health care team and optimize medication use for improved patient outcomes. Keystone First has also implemented its Retail Pharmacy MTM program that assists members with adherence check-ins, consultations, and drug safety reviews at their local pharmacy. The program assisted over 2,800 members in 2018.

United Healthcare has implemented a retail pharmacy MTM program in partnership with Giant Eagle. Pharmacists at Giant Eagle counsel members on medications based on their hospital discharge orders. Pharmacists will also synchronize prescription fills if the member is taking multiple medications and provide follow-up to ensure the member remains compliant.

UPMC uses a team of in-house physicians, clinical pharmacists, analysts, and information technology staff to operate its MTM program. Information technology staff use software designed to identify potential medication issues that the medical staff then address with the member through care management telephonic outreach. Identified issues include: compliance, drug-drug and drug-disease interactions, overuse, high risk medications, gaps in care, high dose, and appropriate lab monitoring.

F. Telemedicine

Telemedicine is the use of real-time interactive telecommunications technology that includes, at a minimum, audio and video equipment as a mode of delivering consultation services[4]. The use of telemedicine has continued to expand the number of visits for both physical and behavioral health conditions. The number of telemedicine visits paid by both the PH-MCOs and BH-MCOs increased from 2011 to 2018. Several data points include:

1. Physical health visits increased from 1,718 in 2011 to 17,669 in 2018.
2. Behavioral health visits increased from 3,624 in 2011 to 43,467 in 2018.
3. In 2018, 71 percent of telemedicine visits were behavioral health.
4. In 2018, 46% of telemedicine visits occurred in rural counties.
5. There were over 61,000 telemedicine visits in 2018.

DHS expects the upward trend of telemedicine visits to continue throughout 2019. OMHSAS continues to review its telemedicine bulletin for behavioral health services to make possible revisions to the current process. OMAP has not planned any specific revisions to its current bulletins but has encouraged the PH-MCOs to work with providers to expand sites of service such as inpatient intensive

[4] https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/d_005993.pdf

care units, stroke units, and emergency departments. OMAP is also encouraging providers to leverage telemedicine with MTM to combat the opioid epidemic.

G. Conclusion

Throughout 2018 and 2019, DHS continued implementation of three programs that impact hundreds of thousands of Medicaid recipients: COEs, PCMHs, and CCBHCs. These programs focus on health delivery redesign, advancement in access to care, improvement in quality, and alternative payment design. DHS has continued to see the expansion of MTM and telemedicine services for those with both physical and behavioral health conditions.

DHS will continue to monitor these programs, taking into consideration the suggestions of the Council and changing medical practices. As technology and evidence-based practices evolve, so too will DHS's efforts to improve health outcomes for the commonwealth's most vulnerable populations.