pennsylvania

DEPARTMENT OF HUMAN SERVICES

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

Submitted to CMS December 2023
And updated September 2024

Table of Contents

Glossary of Acronyms

ACAP Adult Community Autism Program

ADV Annual Dental Visit

AHC AmeriHealth Caritas© Pennsylvania

ASD Autism Spectrum Disorder

BH Behavioral Health

BHARP Behavioral Health Alliance of Rural Pennsylvania

CAAC County Administrators Advisory Committee

CAHPS® Consumer Assessment of Healthcare Providers and Systems

CAP Corrective Action Plan

CAU Comprehensive Assessment and Update

CBO Community-Based Organization

CCBHC Certified Community Behavioral Health Clinic Demonstration

CHC Community HealthChoices

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

CNM Certified Nurse Midwife

COE Center of Excellence

COVID-19 Coronavirus Disease 2019

CPU Care Plan and Update

CY Calendar Year

DHS Department of Human Services or Department

D-SNP Dual Eligible Special Needs Plan

EAC Enrollment Assistance Contractor

ED Emergency Department

EHR Electronic Health Record

EPSDT Early Periodic Screening, Diagnosis and Treatment

EQR External Quality Review

EQRO External Quality Review Organization

FED Functional Eligibility Determination

FFS Fee-for-Service

FPL Federal Poverty Limit

FQHC Federally Qualified Health Center

HC HealthChoices

HC BH HealthChoices Behavioral Health

HC PH HealthChoices Physical Health

HCBS Home- and Community-Based Services

HEDIS® Healthcare Effectiveness Data and Information Set

HIE Health Information Exchange

HQIP Hospital Quality Improvement Program

ICF Intermediate Care Facility

ICP Integrated Care Plan

ICWC Integrated Community Wellness Centers

IEB Independent Enrollment Broker

IPRO Island Peer Review Organization

ISAC Information Sharing and Advisory Committee

KAS Keystone Autism Services

KF Keystone First

L/C Lehigh/Capital

LCD Level of Care Determination

LTSS Long-Term Services and Supports

MA Medical Assistance

MAAC Medical Assistance Advisory Committee

MAT Medication-Assisted Treatment

MATP Medical Assistance Transportation Program

MCE Multiple County Entity

MCO Managed Care Organization

MCQS Managed Care Quality Strategy

MEMM Medicaid Enterprise Monitoring Module

MHSIP Mental Health Statistics Improvement Program

MM Member Month

MY Measurement Year

N/C-CO North/Central-County Option

NCQA National Committee for Quality Assurance

NE Northeast

NF Nursing Facility

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 and Substance Abuse Services

OUD Opioid Use Disorder

P&T Pharmacy and Therapeutics

P3N PA Patient & Provider Network

P4P Pay-for-Performance

PAA Potentially Avoidable Admissions

PAPM Pennsylvania Performance Measures

PCP Primary Care Physician

PCR Plan All-Cause Readmissions

PDL Preferred Drug List

PDN Private Duty Nursing

PH Physical Health

PHE Public Health Emergency

PHW PA Health & Wellness

PIHP Prepaid Inpatient Health Plan

PIP Performance Improvement Project

R&RT Resource and Referral Tool

REAL Race Ethnicity and Language

RHC Rural Health Clinic

RY Rate Year

SAMHSA Substance Abuse and Mental Health Services

SDOH Social Determinants of Health

SE Southeast

SFY State Fiscal Year

SMART Systemic Monitoring and Access Retrieval Technology

SPMI Serious Persistent Mental Illness

SUD Substance Use Disorder

SSI Supplemental Security Income

SW Southwest

TBD To Be Determined

UPMC University of Pittsburgh Medical Center

VBP Value-Based Payment

WCV Well-Care Visits

Purpose

The Centers for Medicare & Medicaid Services (CMS), per regulation 42 CFR § 438.340(a) and 42 CFR 457.1240(e), requires states to have a quality strategy for their managed care programs. The intent of the regulation is to ensure members enrolled in Medicaid and Children's Health Insurance Program (CHIP) managed care programs have access to high quality health care services provided by the state's managed care organizations (MCOs) or entities. This document represents the Managed Care Quality Strategy (MCQS) for Pennsylvania's Medical Assistance (MA) and CHIP where the Pennsylvania Department of Human Services (DHS or Department) contracts with managed care entities for the delivery of services.

The MCQS is a revised version of the previous quality strategy submitted to CMS in December 2020, and describes initiatives, strategies, and processes to improve, evaluate and monitor member access to high quality, timely care through the Medicaid and CHIP managed care delivery system. 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.

This document describes the goals and objectives of the MCQS, how DHS will measure success on those goals and objectives, and tools the Department uses to improve and ensure quality of care.

Scope and Overview of Medicaid and CHIP Managed Care in Pennsylvania

The Pennsylvania MCQS describes the managed care programs and structures, populations served, services offered, goals and objectives, quality-related initiatives and strategies, as well as administrative processes used to assure and monitor quality.

Program Structure, Program Authority and Populations Served (Contracted Entity)

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. The DHS MA and CHIP programs are administered through the following main programs:

1. **HealthChoices (HC)**, which includes:
   a) **HealthChoices Physical Health (HC PH)**, which provides PH (medical care) services through physical health-managed care organizations (PH-MCOs).
   b) **HealthChoices Behavioral Health (HC BH)**, which is a BH carve-out that provides mental health and substance use disorder (SUD) services through county-based entities that contract with Behavioral Health Managed Care Organizations (BH-MCOs) for both HC PH and Community HealthChoices (CHC) members.
   c) **CHC**, which provides PH services along with long-term services and supports (LTSS) through CHC-MCOs for adults who require LTSS, as well as adults eligible for both Medicaid and Medicare (Dual Eligible).
2. **Adult Community Autism Program (ACAP)**, which serves approximately 180 adults in four counties (Cumberland, Dauphin, Chester, and Lancaster). ACAP is a fully integrated program that provides PH, BH and home- and community-based services (HCBS) to adults with an autism spectrum disorder (ASD). ACAP was the first program in the nation to use a single HCBS provider, Keystone Autism Services (KAS), to provide an integrated system of care as a traditional MCO.
3. **Children's Health Insurance Program (CHIP)**, which is operated as a standalone program, serving children with incomes above the MA income thresholds. CHIP provides free or low-cost health insurance to uninsured children and teens that are not eligible for or enrolled in MA. CHIP is available for families whose income is above 133% of the federal poverty level (FPL). Families with incomes greater than 314% of the FPL can purchase coverage by paying the full rate negotiated by the state.[1] CHIP-MCOs cover both PH and BH services.

[1] DHS also used its CHIP funding for the Affordable Care Act Medicaid expansion for children ages six to eighteen. These children are served through HealthChoices.

Table 1 provides detailed information about each of these programs including their managed care type (e.g., MCO, prepaid inpatient health plan [PIHP], etc.), waiver authority, populations served and contracted plans.

Table 1

Program Name	MCO Type	Managed Care Authority	Populations Served	Contracted Entities

HC PH	MCO	1915(b)	• Children, parent/caretaker relatives, pregnant women, Supplemental Security Income (SSI) and expansion populations ages 19–64.
			• Including sub population of children and adults with disabilities who do not require LTSS, and the Breast and Cervical Cancer program.
				• Geisinger Health Plan
				• Health Partners Plans
				• Highmark Wholecare
				• UnitedHealthcare® Community Plan of Pennsylvania
				• UPMC *for You,* Inc.
				• Vista Health Plan
				  ○ AmeriHealth Caritas Pennsylvania (AHC)
				  ○ Keystone First (KF)

HC BH[2]	PIHP	1915(b)	• Children, parent/caretaker relatives, pregnant women, SSI, and expansion populations ages 19–64. • Adults (ages 21 and older) who require LTSS, based on nursing facility (NF) level of care requirements (regardless of whether they are served in a NF or through HCBS). This includes both dual eligibles and non-dual members. • Adults (ages 21 and older) dually eligible members (Medicaid, Medicare) who do not require LTSS.	• Southeast (SE) Zone: Each individual county contracts with a HC BH-MCO – see Figure 4. • Southwest (SW) Zone: Southwest Behavioral Health Management Multiple County Entity (MCE) (Armstrong County, Butler County, Indiana County, Lawrence County, Washington County, and Westmoreland County) contracts with a HC BH-MCO. Other individual counties contract with a HC BH-MCO – see Figure 4. • Lehigh/Capital (L/C) Zone: Berks County, Capital Area Behavioral Health Collaborative MCE (Cumberland County, Dauphin County, Lancaster County, Lebanon County, and Perry County), Lehigh County, Northampton County, and York/Adams

[2] Pennsylvania law (including the Mental Health and Intellectual Disability Act of 1966) assigns responsibility for community-based mental health and drug and alcohol services to local county governments, so county governments were given the "right of first opportunity" in the HC BH program. Therefore, counties have direct agreements with DHS to manage the program as a Primary Contractor; in most cases those counties, either individually or through joinder agreements, enter into a subcontract with a BH-MCO to delegate much of the overall administration of the HC BH benefits.

Program Name	MCO Type	Managed Care Authority	Populations Served	Contracted Entities
				MCE contract with a HC BH-MCO. • Northeast (NE) Zone: The Northeast Behavioral Health Care Consortium MCE (Lackawanna County, Luzerne County, Susquehanna County, Wyoming County) contracts with a HC BH-MCO – see Figure 4. • Behavioral Health Alliance of Rural Pennsylvania (BHARP) Zone: The BHARP MCE contracts with a HC BH-MCO – see Figure 4. North/Central County Option (N/C-CO) Zone: Bedford/Somerset MCE, Blair County, Cambria County, Carbon/Monroe/Pike MCE, Crawford/Mercer/Venango MCE, Erie County, Franklin/Fulton MCE, and Lycoming/Clinton MCE contract with a HC BH-MCO.
CHC	MCO	1915(b), 1915(c)	• Adults (ages 21 and older) who require LTSS, based on NF level of care requirements (regardless of whether they are served in a NF or through HCBS). This includes both dual and non-dual eligible members. • Adults (ages 21 and older) dually eligible members (Medicaid, Medicare) who do not require LTSS.	• Vista Health Plan ○ AHC ○ KF CHC • PA Health & Wellness (PHW) • UPMC *For You* Community HealthChoices

Program Name	MCO Type	Managed Care Authority	Populations Served	Contracted Entities
ACAP	PIHP	1915(a)	Adults (ages 21 and older) who have an ASD diagnosis and substantial functional limitations in three or more major life activities, require an Intermediate Care Facility (ICF) level of care and are not served by other programs.	KAS
CHIP	MCO	CHIP State Plan	Children enrolled in the standalone CHIP program.	• Aetna Better Health® Kids • Capital Blue Cross® • Geisinger Health Plan • Highmark® Choice Company • Keystone Health Plan East (IBC) • KidzPartners (a part of Jefferson Health Plans) • UnitedHealthCare Community Plan of Pennsylvania • UPMC *for Kids*

Ninety-seven percent (97%) of the over 3.5 million individuals in Pennsylvania's Medicaid program are enrolled in a managed care program. Those not enrolled in managed care are enrolled in the Fee-for-Service (FFS) Program. Outside of ACAP and CHIP, each individual enrolled in Pennsylvania managed care is enrolled in both a HC PH-MCO or CHC-MCO and a HC BH-MCO. This MCQS will describe the initiatives required to comply with 42 CFR § 438.330 for all of Pennsylvania's managed care of programs.

Henceforth, references throughout this document to "MCO" include; ACAP, CHIP-MCO, HC PH-MCO, CHC-MCO, and BH-MCO/Primary Contractor.

Quality Management Structure

Department Leadership

In Pennsylvania, the MA and CHIP programs are administered across multiple DHS program offices. Each program office is led by a Deputy Secretary who reports directly to the Secretary of DHS.

Figure 1.

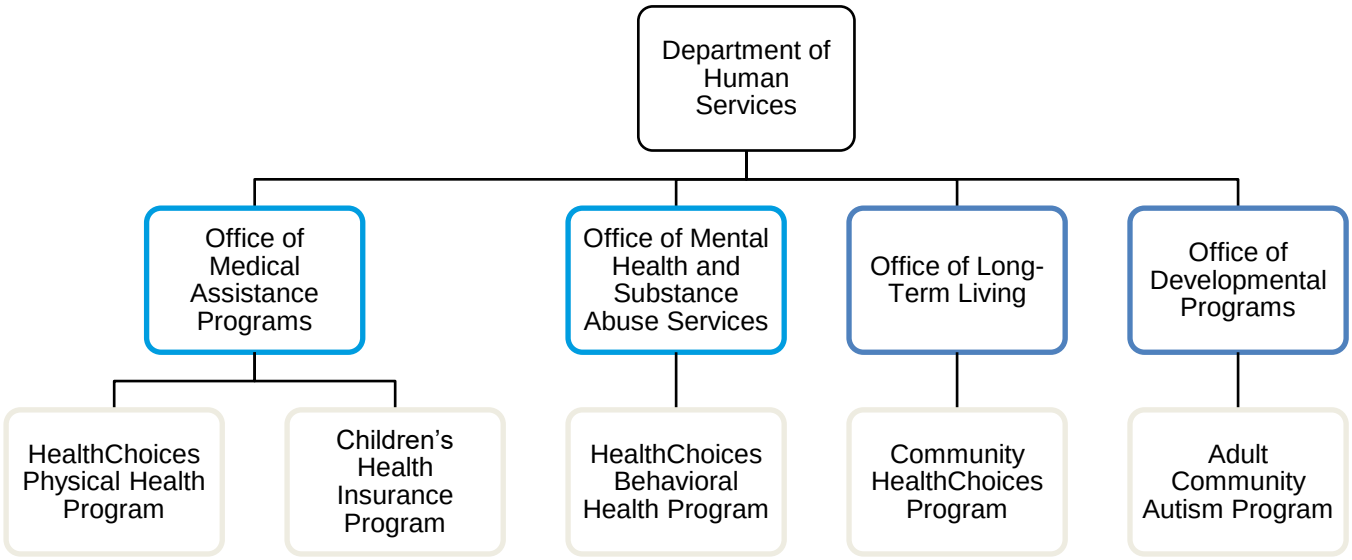


Table 2 outlines the relevant offices, the programs and benefits they administer, and the internal divisions and bureaus responsible for oversight of managed care functions.

Table 2

Office	Program	Benefits	Oversight Entities
Office of Medical Assistance Programs (OMAP)	• HC PH • CHIP	• PH (Medical, Surgical, Prescriptions, Dental) • PH and BH (for CHIP)	• Bureau of Managed Care Operations • Division of Quality and Special Needs Coordination • Division of Monitoring and Compliance • Office of CHIP, Divisions of Operations, Policy and Quality • Bureau of Fiscal Management • Division of HealthChoices Rates
Office of Mental Health and Substance Abuse Services (OMHSAS)	HC BH	BH (Mental Health and Substance Abuse Services)	• Bureau of Community and Hospital Operations • Bureau of Quality Management and Data Review • Division of Medicaid Finance
Office of	CHC	PH and LTSS	• Bureau of Coordinated and

Office	Program	Benefits	Oversight Entities
Long-Term Living (OLTL)			Integrated Services • Bureau of Quality Assurance and Program Analytics • Bureau of Policy Development and Communications Management • Bureau of Finance
Office of Developmental Programs (ODP)	ACAP	PH, BH, and HCBS	Bureau of Supports for Autism and Special Populations

On a regular basis, DHS executive leadership and representatives of each program office attend a meeting hosted by the PeopleStat Office. PeopleStat, an office within the DHS's Secretary's Office, was 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.

DHS's Guiding Principles and Strategic Plan

Each of the five managed care programs are united by a shared mission, guiding principles, and strategic priorities that are synthesized in a single Strategic Plan for DHS. These principles and priorities outlined in the Strategic Plan informed the development of the MCQS and reflect DHS'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.

Guiding Principles

DHS has made the following statements regarding guiding principles:

1. **Person-centered and holistic: DHS** will consider services from the perspective of the person being served and strive to design and provide individualized services that efficiently and compassionately meet the person's needs as a whole.
2. **Relationship-driven:** DHS will recognize and elevate the importance of relationships among the person being served and trusted individuals who can support the person as they seek to develop or maintain physical and emotional well-being, strong families, and economic stability.
3. **Grounded in the community:** DHS will deliver services to people where they live, work, and play, and strive to balance r services to support the ability of people to live in the community. DHS will also work with communities to engage in health improvement.
4. **Informed by data:** DHS will use data and evidence to guide decision-making, continually monitor performance, and engage in quality improvement activities to advance DHS programs.
5. **Collaborative:** In order to deliver coordinated and integrated services in an efficient manner, DHS will work closely with the people we serve and advocates; with our partner agencies in state and federal government; with counties, local government, and local community partners; and with the health and human services organizations and providers DHS relies upon to deliver services.
6. **Innovative:** DHS will identify and implement promising practices and work with DHS partners in the human services system to do the same, and to scale effective practices to maximize the impact.
7. **Equitable:** DHS will work to promote equity for everyone, regardless of race, ethnicity, national origin, gender, sexual orientation, gender identity, age, and disability, so that everyone has an equal opportunity to live the healthiest life possible.

8. **Multi-generational:** DHS will focus on creating opportunities for and addressing the health, economic, and educational needs of children, adults, and seniors as a family unit, using programs and policies designed with the whole family's future in mind to put the family on a path that harnesses their full potential to achieve physical and emotional well-being, economic stability, and resiliency.
9. **Efficient:** DHS will carefully steward taxpayer resources to ensure that dollars are well spent and use continuous incremental improvement (Lean) strategies throughout our programs to empower employees to identify opportunities to increase efficiency so that resources for Pennsylvanians are maximized.
10. **Transparent:** DHS will be transparent with the public, stakeholders, DHS staff, and legislative partners in actions and programs and seek input on the administration of DHS programs.
11. **Delivered by staff who are skilled, supported, and engaged:** DHS will invest in staff to ensure staff have the skills and support needed to provide effective services to the public. DHS will communicate agency goals and priorities clearly so that staff have guidance on DHS expectations.

Strategic Priorities

Medicaid and CHIP Managed Care are a subcomponent within the DHS statewide program. The MCQS looks to the overarching DHS Strategic Plan and priorities set by the Governor's administration for guidance to provide consistency and alignment for Managed Care enrollees.

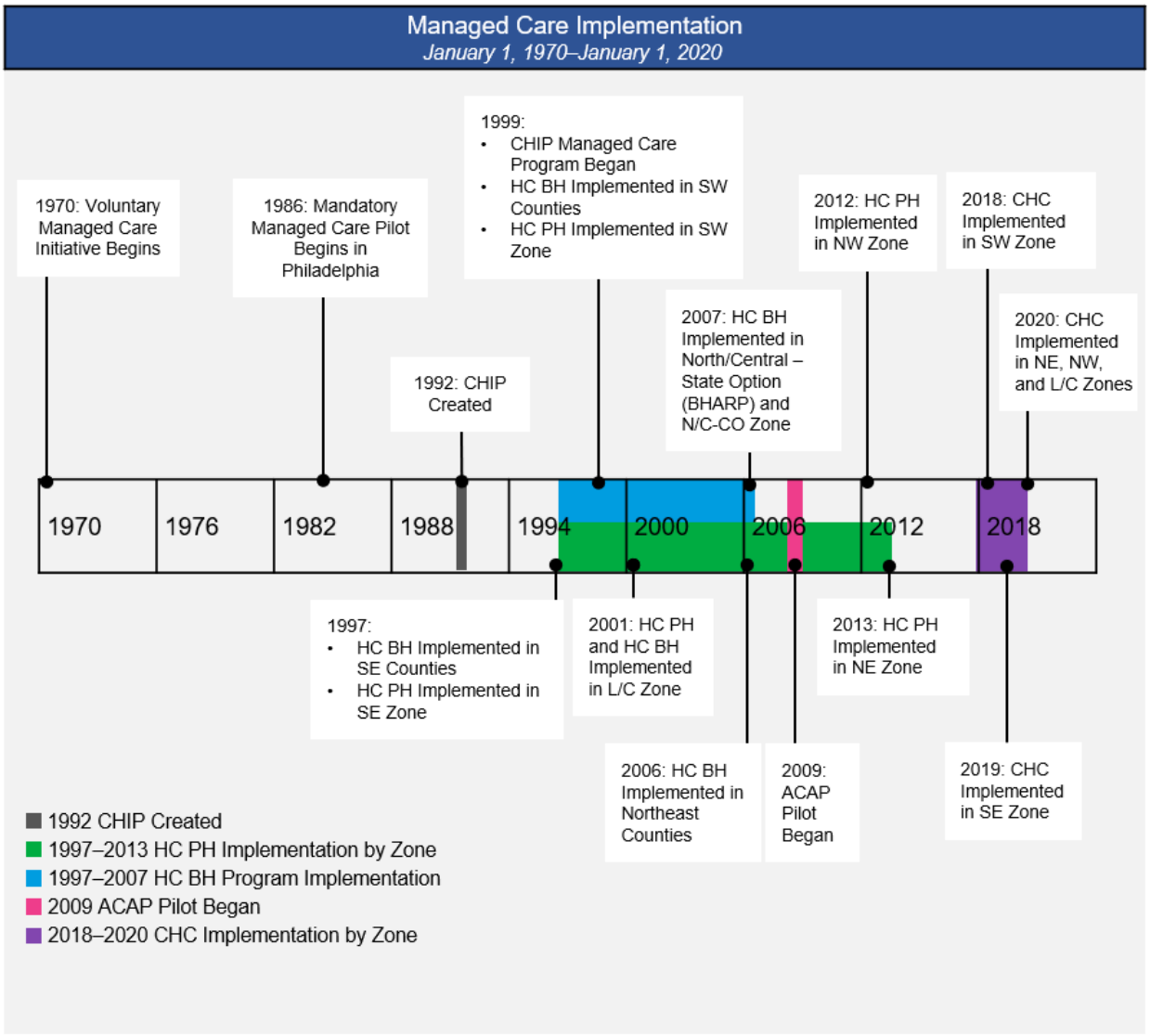
Pennsylvania Managed Care History and Regional Structure

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. Figure 2 depicts a timeline of managed care implementation in Medicaid and CHIP in Pennsylvania, beginning in 1970 and ending in 2020 when the most recent managed care transitions were implemented. Pennsylvania used a phased-in approach to adopt statewide mandatory managed care in the HC PH, HC BH, and CHC. HC PH and CHC operate in five consistent zones as shown on the map in Figure 3.

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. HC BH also follows a zone approach as shown in Figure 4, this footprint varies slightly from HC PH and CHC given the counties have the "first right of opportunity" to manage the program.

Zones are currently not used in CHIP and ACAP.

Figure 2. Managed Care Implementation Timeline in Pennsylvania



While the goals, objectives, and quality measures in the MCQS are statewide measures, offices that use zones can, on a case-by-case basis, drill down either by zone or by specific MCO for a more detailed analysis and trending. In these instances, zonal analyses can be used to determine regional effects in cost, quality performance measure results, demographics, penetration of services, and identification of disparities in performance between MCOs and within each MCO across different regions. This allows for targeted interventions that address unique issues that may be contributing to health outcome variation by zone or MCO.

Figure 3. Map of Pennsylvania's Managed Care Zones – HC PH and CHC

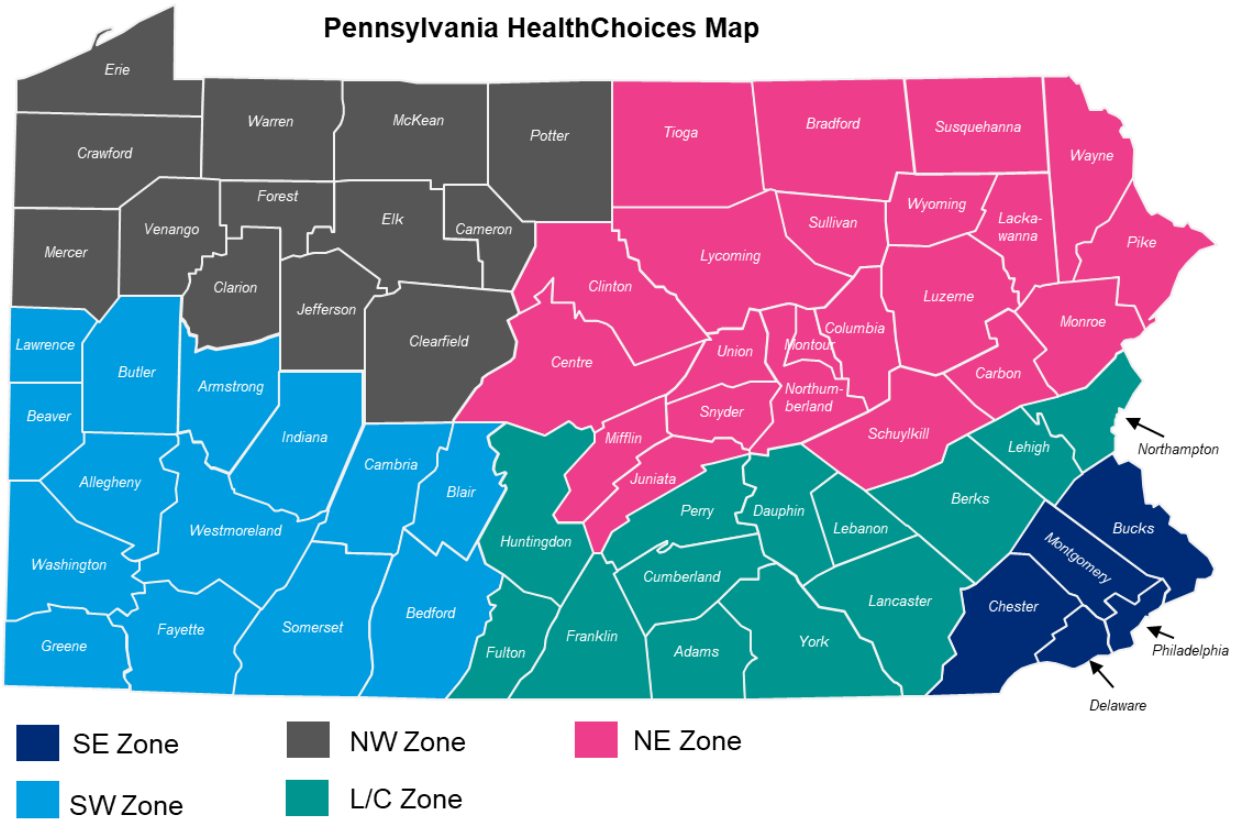
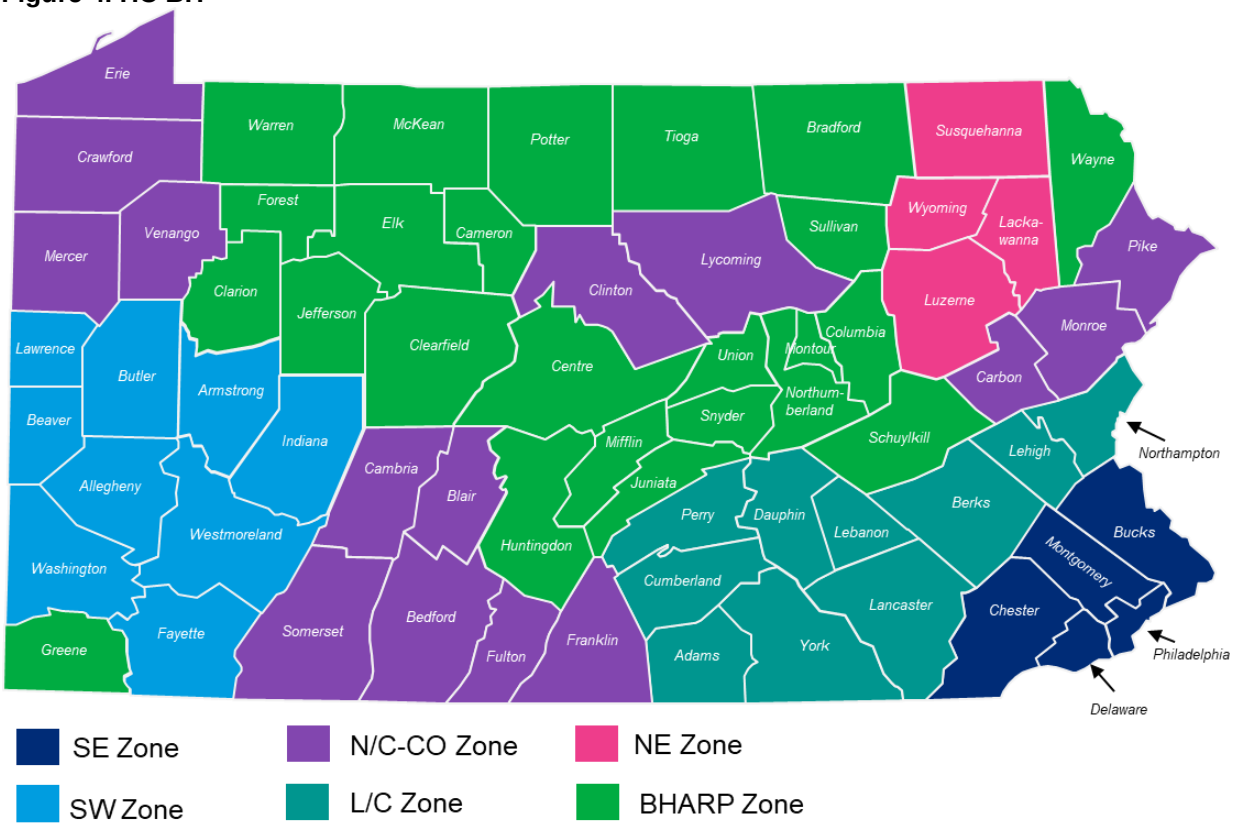


Figure 4. HC BH



Development and Review of the MCQS

DHS develops the MCQS through an interdisciplinary team with representatives from all programs described above who inform and contribute to setting the quality direction of the programs. This team uses the results of ongoing program monitoring, MCO performance on both contractual obligations and performance measures (as evaluated through the External Quality Review Organization (EQRO), feedback from stakeholders and the overall strategic vision of the department's leadership to formulate a comprehensive strategy that will help DHS achieve its desired quality goals.

As part of the development, DHS evaluated the influence of cross-cutting considerations and is aligning its goals and objectives to other quality initiatives such as directed payments, disparity initiatives, its External Quality Review (EQR) activities and others. The goals and objectives outlined in this MCQS are consistent with DHS's overarching priorities and initiatives. As discussed in more detail later in this document, development decisions were also informed by the impact of the Coronavirus Disease 2019 (COVID-19) pandemic, which affected the Commonwealth's ability to drive important initiatives forward, MCO ability to implement those initiatives, provider service delivery and member access to care. In addition, uncertainty around post-pandemic impacts on care delivery including workforce and supply challenges informed the strategy development. The pandemic also highlighted the need for a continued focus on health equity, as well as opportunities for changes in how services are delivered such as expanding telehealth opportunities. DHS considered these impacts and changes in the development of updated goals and objectives for the MCQS.

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 advantage of more real time quality measurement through health information exchange (HIE). This MCQS will be updated and re-submitted to CMS every three Calendar Years (CYs) or whenever federal or state statutory changes, or

other significant changes necessitate changes be made to the MCQS.

DHS defines “significant change” as any change required as a result of state or federal legislation, regulation, or policy changes that could impact the quality strategy or quality monitoring; overall changes to the approach DHS takes to quality; a change in the managed care structure (e.g., large changes to populations included or excluded from managed care); or changes that significantly impact how MCOs deliver care to beneficiaries.

Within this 3-year update of the MCQS, DHS has refocused and revised quality goals, objectives and strategies to reflect priorities including alignment across DHS departments.

Stakeholders

DHS believes stakeholder input is critical to a representative MCQS and engages with several stakeholder groups that act in an advisory capacity related to managed care programs. In addition, DHS sought input on this MCQS from the 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 in the Pennsylvania Bulletin.

The MCQS is posted on DHS’s website at https://www.pa.gov/en/agencies/dhs/resources/medicaid/managed-care-quality-strategy.html and will be updated as needed.

Medical Assistance Advisory Committee (MAAC) — As set forth in the MAAC’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 MA programs from a participant or consumer perspective; the Managed Care Long-Term Services and Supports and Long-Term Services and Supports Subcommittees, which advise DHS on key initiatives and issues related to the CHC program; and the Managed Care Delivery System Subcommittee, which serves as a forum for PH-MCOs and BH-MCOs and advocates to advise about the delivery of health care service to the consumers who receive their health care through the MCOs.

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 BH 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 affecting mental health, substance abuse, BH disorders, and cross-system disability.

Children’s Health Insurance Program Advisory Council — This council is tasked with reviewing outreach activities and may make recommendations to DHS. In addition, this 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.

Because Pennsylvania does not have any recognized Tribes within the geographic boundaries of the Commonwealth and does not have Indian Health Programs or Urban Indian Organizations that furnish health care services, it does not have a tribal consultation policy.

Managed Care Goals and Objectives and Measures

The following goals and their associated objectives and measures align with the mission and values of DHS. DHS developed them by reviewing its existing quality measures, strategies and initiatives, how it evaluates performance of its MCOs, its EQR arrangements, and performance on existing Medicaid and CHIP Child and Adult Core Sets. DHS identified opportunities for improvement that align with the overall agency strategic direction, and linked together goals, objectives and measures that are specific, measurable, attainable, relevant and time-bound. Collectively, these address each population and the managed care plans that serve Pennsylvanians. The end goal of any measure is to evaluate member health outcomes. However, some initiatives are in their early-phase and therefore DHS has determined process measures are appropriate in the short-term.

Some of the measures use nationally normed measure sets (e.g., CMS Adult and Child Core Sets, Healthcare Effectiveness Data, and Information Set [HEDIS]), while others are Pennsylvania-specific and tailored to DHS initiatives. To the extent that measure stewards (e.g., National Committee for Quality Assurance [NCQA]) retire or change their measures or specifications, DHS will review the changes and may update measures accordingly during this MCQS period. For example, NCQA added LTSS measures focused on comprehensive assessments and re-assessments and the sharing of care plans and inpatient discharge, and DHS updated these measures accordingly.

Each Medicaid and CHIP managed care program has unique specific goals and objectives, but they all relate back to three main goals:

1. Increase access to healthcare services.
2. Improve the health outcomes of populations.
3. Promote efficient and effective use of taxpayer resources.

Focused Domains

Under each goal, DHS has identified related objectives as well as metrics that can assess whether the state is making progress on the goals and objectives (including statewide baseline measurements and performance targets). DHS has also established themes, or domains, that link priorities across the goals: increasing value, supporting health equity, and addressing social determinants of health (SDOH). A focus on value is designed to ensure the highest quality of care is delivered for the lowest total cost. This priority is reflected not only in DHS's value-based purchasing initiatives but also throughout the goals and objectives in this MCQS, designed to ensure beneficiaries are receiving the right care, in the right setting, at the right time, and the providers receive the right financial incentive to support improved beneficiary health. Key to high-value health care is a focus on health equity, which is defined by the American Public Health Association as everyone having the opportunity to attain their highest levels of health.[3] DHS believes that its initiatives should support health equity for all beneficiaries, and the goals and objectives of this quality strategy support these efforts. Finally, neither high-value care nor health equity is possible without addressing underlying SDOH that impact member health outcomes. Therefore, DHS is systematically integrating measures that address SDOH into its healthcare system, its initiatives and the goals and objectives of this MCQS.

Pandemic and Post-Public Health Emergency Impacts

The impact of the COVID-19-pandemic, as well as ongoing health care delivery system pressures, informed the development of this strategy. The pandemic had direct impacts on:

- Member care patterns: Members accessed care in different patterns during the pandemic, many avoiding non-urgent care (which has the potential for rebound utilization as untreated conditions

[3] American Public Health Association, Health Equity: https://www.apha.org/Topics-and-Issues/Health-Equity.

worsen) or seeking care in high-cost situations because of limitations on access to regular providers.

- How providers offer care and provider capacity: Many providers not only placed restrictions on the types of care offered (often out of necessity due to the need to prioritize COVID-19 related care, or to comply with mitigation requirements) but changed care access modalities such as increasing telehealth options. DHS plans to continue to leverage the use of telehealth following the Public Health Emergency (PHE) as an effort to support network accessibility.
- DHS and MCO initiatives: Because the pandemic had such a broad impact on Medicaid and CHIP program operations, DHS and its MCO partners had to shift focus to the emergent needs of the pandemic and implement programmatic changes necessary for pandemic response. While the pandemic also highlighted opportunities for future innovation and efficiency, it affected progress on many quality initiatives.

Economic and workforce changes are also influencing care delivery in ways that will extend beyond the end of the PHE. Employers are facing significant workforce challenges and efforts to respond are ongoing for the health care system. Many providers (as well as MCOs and states) are struggling to retain sufficient employees to return to pre-pandemic staffing levels, which will undoubtedly affect how care is delivered. Supply chain pressures affect the delivery of needed equipment, which also impacts a provider's ability to timely deliver care. Health care stakeholders are still responding to these significant changes and the impacts on future care delivery are unclear. As DHS developed goals, objectives, and associated metrics (and targets) in this context, it was clear that there were many uncertainties about how the health care infrastructure would respond to these challenges and this affected the perspective on the potential for success in moving the needle on objectives. Even deciding the appropriate baseline upon which to measure progress was difficult and the decisions made varied based on the impacts of the above issues on the specific metrics in question.

The PHE ended on May 11, 2023, but the lack of certainty around the impact of unwinding efforts continues to inform the discussion. As DHS set baselines and targets, the influence of the changes in population (and population acuity) that come with the unwinding and the effect the changes will have on metric results were considered. For example, children who enrolled in Medicaid during the PHE may move to CHIP once redetermination processes fully resume. If individuals who are no longer eligible for Medicaid and are disenrolled during the unwinding have different care needs or utilization patterns than those who remain eligible and enrolled, those differences will also affect measure results.

Therefore, it will be important for all parties to be flexible and adaptable in monitoring progress on goals and objectives during these uncertain times.

Table 3 below provides the linked goals, objectives, and metrics. The table also indicates whether an objective relates to an approved State Directed Payment arrangement.

The MCQS, measures and performance outcomes that demonstrate progress on the quality strategy can be found through the following link: https://www.pa.gov/en/agencies/dhs/resources/medicaid/managed-care-quality-strategy.html

Table 3.

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
Goal: Increase Member Access to Healthcare Services				

OMAP	Access to physician services at academic medical centers
	• **Directed Payment**
	  ○ Network access — medical school in Philadelphia not affiliated with state related academic medical center located in a city of the first class
	• **Directed Payment**
	  ○ Network access — state related academic medical center located in a city of the first class
		Maintain service utilization for Medicaid beneficiaries enrolled in managed care for primary care and specialty physician services provided by physician practice plans in the specified provider class	OMAP
			• Calendar Year (CY) 2023: TBD
				OMAP
				• TBD, once baseline is established

OMAP and OMHSAS	Decrease emergency department utilization (EDU), inpatient admissions, and readmissions for individuals with serious persistent mental illness (SPMI)	Decrease EDU-ICP Emergency Department (ED) Visits/1,000 SPMI-Defined Member Month (MM) decrease by 10% from Measurement Year (MY) 2019 to MY 2024 for individuals with SPMI	OMAP and OMHSAS • MY 2019: 138.98 (this is the statewide PH and BH rate)	OMAP and OMHSAS • MY 2024: 125.08
		Combined BH/PH Inpatient Admission Utilization for individuals with SPMI, Discharges/1,000-Defined MM decrease by 5% from MY 2019 to MY 2024 for individuals with SPMI	OMAP and OMHSAS • MY 2019: 27.80 (this is the statewide PH and BH rate)	OMAP and OMHSAS • MY 2024: 26.41

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
		Combined BH/PH Inpatient 30-Day Readmission for individuals with SPMI, Decrease Total 30-Day Readmissions by 3% from MY 2019 to MY 2024 for individuals with SPMI	OMAP and OMHSAS • MY 2019: 16.99% (this is the statewide PH and BH rate)	OMAP and OMHSAS • MY 2024: 16.14%
OMAP	Maintain or increase access to inpatient hospital services • **Directed Payment** ○ Inpatient and outpatient hospital access	Inpatient Acute Care General Hospital capacity measured by the count of open and enrolled service locations by end of CY with adequate run out time to process all enrollment packets for the CY	OMAP • CY 2022: 95%	OMAP • MY 2024: 95%
OMAP	Maintain or increase access to outpatient hospital services • **Directed Payment** ○ Inpatient and outpatient hospital access	Number of Acute Care General Hospitals providing outpatient hospital services measured by the count of open and enrolled service locations by end of CY with adequate run out time to process all enrollment packets for the CY	OMAP • CY 2022: 95%	OMAP • MY 2024: 95%
	Maintain or increase access to outpatient hospital services	Adults' access to preventive/ambulatory health services HEDIS	OMAP • MY 2019 rate: 80.97%	OMAP • MY 2024: Achieve and/or exceed MY 2019 rates
		Rate of ambulatory care/outpatient visits	OMAP • MY 2019 rate: 351.53%	OMAP • MY 2024: Achieve and/or exceed MY 2019 rates
OMAP	Increase initiation and engagement in drug dependence treatment by incentivizing follow-up after ED visit with opioid use disorder (OUD) diagnosis	Number/percentage of hospitals who qualify for incentive payment by attaining improvement by at least 0.5% on seven-day OUD follow-up treatment initiation rate compared to 2021	OMAP • 2021: 72.4%	OMAP • MY 2024: Achieve and/or exceed CY 2021 percent

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
	• **Directed Payment** ○ Increase initiation and engagement in OUD treatment following an ED visit — Hospital Quality Improvement Program (HQIP)	Number/percentage of hospitals achieving at least the 50th percentile of 2021 statewide seven-day OUD follow-up treatment initiation rate	OMAP • 2021: 36.08% = 50th percentile • 44.0% = 75th percentile	OMAP • MY 2024: Improvement of at least 0.5% over baseline at or above the 50th percentile
OMHSAS	Increase access to care through use of Integrated Community Wellness Centers (ICWCs) • **Directed Payment** ○ Increase Follow-up after Mental Health Hospitalization	Increase Adult 30-day Follow-up after Mental Health Hospitalization to 41.60%	OMHSAS • SFY 2019: 22.70%	OMHSAS • CY 2023: 41.60%
	Increase access to care through use of ICWCs • **Directed Payment** ○ Maintain 100% of 30-day after Mental Health ED Visit	Maintain 30-day Follow-up after Mental Health ED Visit Ages Six and Over of 100%	OMHSAS • SFY 2019: 100%	OMHSAS • CY 2023: 100%
OMHSAS	Increase access to care through use of ICWCs • **Directed Payment** ○ Increase Initiation and Engagement of Treatment of Alcohol and Other Drug Abuse or Dependence Treatment	Increase Initiation and Engagement of Treatment of Alcohol and Other Drug Abuse or Dependence Treatment to: • Initiation: 28.20% • Engagement: 19.30%	OMHSAS • Initiation: SFY 2019: 15.00% • Engagement: SFY 2019: 4.80%	OMHSAS • Initiation: CY 2023: 28.20% • Engagement: CY 2023: 19.30%

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
OLTL	Increase the percentage of members being served in their home or community	MCOs to assist at least 425 people on an annual basis for transition	OLTL CY 2022: • Statewide: 1,517 • AHC/KF: 680 • PHW: 410 • UPMC: 427	OLTL: CY 2023 • Identification of at least 425 members per year per MCO to transition from NF to community
		Goal that less than 5.0% of people who transitioned to community will be re-institutionalized for less than four of the six months post-discharge	OLTL CY 2022: • Statewide: 4.1% • AHC/KF: 3.4% • PHW: 5.1% • UPMC: 4.2%	OLTL: CY 2023 • MCO to have less than 5.0% of members re-institutionalized after transferring from NF to community
OLTL	Increase the percentage of members being served in their home or community	The MCOs will assist 404 participants who transitioned from the NF to the community and remained in the community for at least four of the six months	OLTL CY 2022 • Statewide: 1,455 • AHC/KF: 657 • PHW: 389 • UPMC: 409	OLTL:CY 2023 • 404 participants who transitioned from the NF to the community and remained in the community for at least four of the six months
OLTL	Maintain or increase access to nursing facility services for medically necessary care. • **Directed Payment** ○ Nursing facility access	Number of Nursing Facilities measured by the count of open and Medicaid enrolled providers by the end of the CY.	OLTL • CY 2022: 611 – Facilities Count	OLTL • CY 2023: Maintain or increase facility count from 2022 level.
OLTL	Develop and implement educational programs and VBP initiatives for NF Services: in coordination with NF representatives, implement educational programs and VBP initiatives to improve care coordination and health and safety outcomes for NF participants	Percentage of short-stay residents who were re-hospitalized after a NF admission	OLTL CY 2021 • 19.33%	OLTL: CY 2023 • 0.5% improvement
		Percentage of long-stay residents with pressure ulcers	OLTL CY 2021 • 7.75%	OLTL: CY 2023 • 0.5% improvement
		Percentage of long-stay residents experiencing one or more falls with major injury	OLTL CY 2021 • 3.20%	OLTL: CY 2023 • 0.5% improvement

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
	○ This includes initiatives supporting improvements such as reducing hospitalizations, reducing pressure ulcers, improving immunization rates, reducing falls, and reducing the use of antipsychotic medications • **Directed Payment** ○ Lead the healthcare system toward VBP coordinated across payers	Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine	OLTL CY 2021 • 94.71%	OLTL: CY 2023 • 0.5% improvement
		Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine	OLTL CY 2021 • 88.84%	OLTL: CY 2023 • 0.5% improvement
		Percentage of long-stay residents who received an antipsychotic medication	OLTL CY 2021 • 15.82%	OLTL: CY 2023 • 0.5% improvement
OMAP, OLTL and CHIP	Increase Annual Child and Adult Dental Visits Note: NCQA retired the HEDIS measure Annual Dental Visits (ADV). For MY2023, OMAP and CHIP developed a PAPM to continue measuring the child annual dental visits. DHS will use Oral Evaluation, Dental (OED) Services for OMAP children and CHIP in MY2024. OLTL will continue to measure the	• Return the PAPM measure to pre-pandemic (MY 2019) levels by MY 2023 • Note: NCQA retired the ADV measure for MY 2023 ○ OMAP and CHIP are using HEDIS ADV for child MY2019 baseline rate. ○ OLTL will continue to measure the PAPM for Annual Adult Dental Visits	OMAP and CHIP child: • OMAP child: MY 2019: 65.80% • OMAP child: MY 2020: 54.23% • CHIP: MY 2019: 72.23% • CHIP: MY 2020: 56.89% OLTL: • OLTL: MY 2021: 20.44%	OMAP and CHIP child: • Annual Child Dental Visits to pre-pandemic (MY 2019) levels by MY 2023 ○ OMAP: : 65.80% ○ CHIP: 72.23% OLTL: • OLTL: 22.10%

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
	PAPM for Annual Adult Dental Visits.			
	Increase Lead Screening	Increase the percentage of children receiving an Annual Lead Screening (HEDIS) by 3% from MY 2020 to MY 2024	OMAP and CHIP • OMAP: MY 2020: 83.22% • CHIP: MY 2020: 74.69%	OMAP and CHIP • Annual Lead Screening (HEDIS) by 3% from MY 2020 to MY 2024 • OMAP: 3% increase of 83.22: 85.72% • CHIP: 3% increase of 74.69: 76.93%
OMAP, CHIP, and OLTL	Decrease ED utilization and inpatient admissions and readmissions	Return HEDIS ED Visits/1,000 MM to pre-pandemic (MY 2019) levels by MY 2024	OMAP, CHIP, and OLTL • OMAP: MY 2019: 66.06 • CHIP: MY 2019: 26.59 • OLTL (non-duals and aligned D-SNP): MY 2019: 0.05	OMAP, CHIP, and OLTL • OMAP MY 2024: 64.08 • CHIP: MY 2024: 25.79 • OLTL: MY 2024 (non-duals and aligned D-SNP): perform better than the HEDIS 75th percentile
		Return HEDIS inpatient admissions — Total Discharges/1,000 MM to pre-pandemic (MY 2019) levels by MY 2024	OMAP, CHIP, and OLTL • OMAP: MY 2019: 6.60 • CHIP: MY 2019: 0.69 • OLTL (non-duals and aligned D-SNP): MY 2019: 28.18	OMAP, CHIP, and OLTL • OMAP: MY 2024 — within the threshold of 0.198 above or below the MY 2019 rate of 6.60 • CHIP: MY 2024- within the threshold of 0.02 above or below the MY 2019 rate of 0.69. • OLTL: MY 2024 (non-duals and aligned D-SNP): perform better than the HEDIS 75th percentile

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
OMAP and OLTL	Decrease ER utilization and inpatient admissions and readmissions	HEDIS Plan All-Cause Readmissions (PCR): Count of Expected/Observed 30-Day Readmissions Ratio	OMAP and OLTL • OMAP: ○ PCR: Count of Expected/Observed 30-Day Readmissions Ratio ○ MY 2019: 1.08 (PH weighted average) ○ MY 2020: 1.02 (PH weighted average) ○ PCR Observed Readmission Rate Total 2019: 9.87% (PH weighted average) 2020: 10.02% (PH weighted average) • OLTL (non-duals and aligned D-SNP): observed weighted average ○ MY 2019: 28.18 ○ MY 2020: 31.49	OMAP and OLTL • OMAP: MY 2024 rate of 1.0 • OLTL: MY 2024 (non-duals and aligned D-SNP): perform better than the HEDIS 75th percentile
ODP	Improve care for individuals with autism in the communities where they live, work, and are actively involved	By 2024, 90% of members will have maintained or increased the number of hours worked	ODP • 2021: 64%	ODP • 2024: 90%
		By 2024, 90% of members will have had a dental exam	ODP • 2021: 76%	ODP • 2024: 90%
		By 2024, 50% of members will decrease or maintain (if at eight) their social isolation score (social isolation scores range from eight to 40)	ODP • 2021: 34%	ODP • 2024: 50%
OMAP	Ensure adequate, timely access to primary care	Percentage of in-network Primary Care Physicians (PCPs) reporting open panels	OMAP • MY 2022: open panels are at 92%	OMAP • MY 2024: Open panels will remain at or above 92%

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
OMAP and CHIP	Reduce racial disparities for African American members in select quality measures	• Reduction of racial disparities for African American members for the following HEDIS measure: ○ Improve prenatal care in the first trimester by 3% from MY 2020 to MY 2024	OMAP and CHIP • OMAP African American members Rate: prenatal care in the first trimester — MY 2020: 85.86% • CHIP: baseline metric, to be developed as this is a new metric for CHIP	OMAP and CHIP • OMAP: improve prenatal care in the first trimester by 3% from MY 2020 to MY 2024: 88.44% • CHIP: TBD, once baseline is established
		• Reduction of racial disparities for African American members for the following HEDIS measures: ○ Well-Child Visits in the first 30 months of life ○ Well-Child Visits in the first 15 months age band	OMAP and CHIP • OMAP African American Rate: ○ Well-Child Visits in the first 30 months of life ○ Well-Child Visits in the first 15-month age band — MY 2020: 56.40% • CHIP: baseline metric, to be developed as this is a new metric for MY 2023.	OMAP and CHIP • OMAP: improve Well-Child Visits in the first 30 months of life and Well-Child Visits in the first 15-month age band by 5% from MY 2020 to MY 2024: 59.22% • CHIP: TBD, once baseline is established
		• Reduction of racial disparities for African American members for the following HEDIS measure: ○ Child and Adolescent Well-Care Visits (WCVs)	OMAP and CHIP • OMAP African American Rate: ○ Child and Adolescent WCVs (Total) — MY 2020: 48.63% • CHIP: baseline metric, to be developed as this is a new metric for CHIP	OMAP and CHIP • OMAP: improve child and adolescent WCVs by 5% from MY 2020 to MY 2024: 51.06% • CHIP: TBD, once baseline is established

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
OMAP	Reduce racial disparities for African American members in select quality measures	• Reduction of racial disparities for African American members for the following HEDIS measure: ○ Controlling High Blood Pressure (CBP)	OMAP • MY 2021 • African American members: 57.14%	OMAP: An increase of 3.0% from MY 2021 to MY2024
		• Reduction of racial disparities for African American members for the following HEDIS measure: ○ The MY2021 baseline will be based on CDC-HbA1c poor control >9%. ○ Hemoglobin A1c Control for Patients With Diabetes (HBD) – we are only looking to reduce disparities for the poor control cohort >9%.	OMAP • MY 2021 • African American members: 44.77%	OMAP: A decrease of 3.0% from MY 2021-MY2024
OMHSAS	Reduce racial disparities for African American members in select quality measures	• Reduction of racial disparities for African American members for the following HEDIS measure: ○ Improve Follow-up after Hospitalization for mental illness at 7-Days by ≥ 2%. ○ Improve Follow-up for mental illness at 30-Day by ≥ 2%.	OMHSAS • MY 2021: • African American Members: 30.2%	OMHSAS: An increase by 2% or more for MY 2023 – 2025.

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
OMAP	Preserve access to private duty nursing (PDN) services for members under the age of 21 • **Directed Payment** ○ Preserve access to PDN services for members under the age of 21	Decrease the percentage of missed shifts from the baseline by 0.5%	OMAP • 2022: 14%	OMAP • MY 2024: A decrease of 0.5% from the baseline from 2022
OMAP	Preserve access to emergency services for members residing in and near the cities of Pittsburgh and Philadelphia • **Directed Payment** ○ Preserve access to emergency services for members residing in and near the cities of Pittsburgh and Philadelphia	Preserve cities of Pittsburgh and Philadelphia ambulance utilization in CY 2023 at least to CY 2019 levels (based on utilization)	OMAP • City of Pittsburgh ambulance CY 2019 utilization: 12,886 ambulance units • Philadelphia ambulance CY 2019 utilization: 45,503 ambulance units	OMAP MY 2023 • 90% maintenance of CY 2019 ambulance services utilization for cities of Pittsburgh and Philadelphia

CHIP	Increase contraceptive use in postpartum members	Contraceptive Care for postpartum women ages 15–20; increase by 2% from MY 2020 to MY 2024	CHIP
			• MY 2020:
			  ○ Rate 1: 15.87%
			  ○ Rate 2: 53.97%
			  ○ Rate 3: 9.52%
			  ○ Rate 4: 15.87%
				CHIP
				• MY 2024 at 2% increase:
				  ○ Rate 1: 16.19%
				  ○ Rate 2: 55.05%
				  ○ Rate 3: 9.71%
				  ○ Rate 4: 16.19%

OMHSAS	Increase SDOH screenings and referrals specifically reported by the ICWCs	Any increase in the number of screenings and referrals reported by the ICWCs	OMHSAS • CY 2022: Baseline starting as 0 for new measure	OMHSAS: CY 2023 • Overall increase in the number of SDOH screenings

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
Goal: Improve the Health Outcomes of Populations				
OMAP		• Controlling High Blood Pressure (CBP) – all populations	MY2021: 65.22%	OMAP: Increase of 3% from MY2021 to MY2024
		HbA1c Poor Control • The MY2021 baseline will be based on CDC-HbA1c poor control >9%. • Hemoglobin A1c Control for Patients With • Diabetes (HBD) – we are only looking to reduce the poor control cohort >9%.	MY2021: 36.05%	OMAP: Decrease of 3% from MY2021 to MY2024
OMAP and CHIP	Improve utilization of key preventive services	OMAP • Increase Well-Child Visits in the first 30 months of life (15-month age band) by 5% from MY 2020 to MY 2024 • Increase Well-Child Visits in the first 30 months of life (15-30 month age band) by 2% between MY 2020 and MY 2024 CHIP • Increase Well-Child Visits in the first 30 months of life (0-15 months age band) by 3% from MY 2020 to MY 2024 • Increase Well-Child Visits in the first 30 months of	OMAP and CHIP • OMAP: ○ Well-Child Visits in the first 30 months of life (15-month age band) — MY 2020: 65.19% ○ Well-Child Visits in the first 30 months of life (15–30 month age band) — MY 2020: 74.61% • CHIP: ○ Well-Child Visits in the first 30 months of life (0-15 months age band) — MY 2020:	OMAP and CHIP • OMAP ○ MY 2024: Well-Child Visits in the first 30 months of life (15-month age band) — 68.45% ○ Well-Child Visits in the first 30 months of life (15–30-month age band) — 76.10% • CHIP: ○ MY 2024: Well-Child Visits in the first 30 months of life (0-15 months age band) — 62.09% ○ Well-Child Visits in the first 30 months of life (15–30-months age band — 92.23%)

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
		life (15-30 months age band) by 3% between MY 2020 and MY 2024	60.28% ○ Well-Child Visits in the first 30 months of life (15–30 months age band) — MY 2020: 89.54%	
OMAP and CHIP	Improve utilization of key preventive services	Increase child and adolescent WCVs (Total) by 5% between MY 2020 and MY 2024	OMAP and CHIP • OMAP: child and adolescent WCVs (Total) — MY 2020: 54.60% • CHIP: MY 2020: 63.46%	OMAP and CHIP • OMAP: increase child and adolescent WCVs (Total) by 5% between MY 2020 and MY 2024: 57.33% • CHIP: increase child and adolescent WCVs (Total) by 5% between MY 2020 and MY 2024: 66.63%
		Increase Asthma Medication Ratio by 3% between MY 2020 and MY 2024	OMAP and CHIP • OMAP: Asthma Medication Ratio — MY 2020: 64.79% • CHIP: MY 2020: 76.09%	OMAP and CHIP • OMAP: increase Asthma Medication Ratio by 3% between MY 2020 and MY 2024: 66.73% • CHIP: increase Asthma Medication Ratio by 3% between MY 2020 and MY 2024: 78.37%

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
OMHSAS	Increase length of engagement in treatment for SUD through counseling and Medication-Assisted Treatment (MAT) • **Directed Payment** ○ Increase length of engagement in treatment for SUD through counseling and MAT	Follow-up after ED visit of alcohol and other drug dependence increase by 1% by 2023	OMHSAS • AOD : 2019 ○ Thirty-day follow-up after SUD ED visit: 84.3% ○ Seven-day follow-up after SUD ED visit: 29.0%	OMHSAS • AOD: 2023 ○ Thirty-day follow-up after SUD ED visit: 85.1% ○ Seven-day follow-up after SUD ED visit: 31.5%
OMHSAS	Increase length of engagement in treatment for SUD through counseling and MAT • **Directed Payment** ○ Increase length of engagement in treatment for SUD through counseling and MAT	Continuity of pharmacotherapy for OUD by 1% annually	OMHSAS • CY 2019: 47.501%	OMHSAS • CY 2023: 48.501%
OLTL	Increase the number of LTSS members with a Comprehensive Assessment and Update (CAU)	Maintain or exceed the rate of 78% for members with a CAU	OLTL • MY 2022: 92.2%	OLTL • MY2023:93% of members with a CAU
OLTL	Increase the number of LTSS members with a Comprehensive Care Plan and Update (CPU)	Maintain or exceed the rate of 78% for members with a CPU	OLTL • MY 2022: 85.2%	OLTL • MY 2023: 93% of members with a CPU
	Increase the number of LTSS members with a Reassessment and Care Plan Update after Inpatient Discharge (RAC)	Maintain or exceed the rate of 38% for members with a RAC	OLTL • MY 2022: 46.9%	OLTL • MY 2023: 40% of members with a RAC

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
	Increase the number of LTSS members with a Shared Care Plan with PCP (SCP)	Maintain or exceed the rate of 55% for members with a SCP	OLTL • MY 2022: 67.2%	OLTL • MY 2023: 70% of members with a SCP
OMAP and OMHSAS	Increase organizational cultural and linguistic capacity to reduce health disparities	Maintain percentage of MCOs achieving NCQA distinction in Multicultural Health Care or Health Equity Accreditation at 100% through 2026	OMAP and OMHSAS • All PH and BH MCOs have obtained NCQA distinction in Multicultural Health Care or Health Equity Accreditation (100%)	OMAP and OMHSAS • 100% of all PH and BH MCOs maintain/achieve NCQA distinction in Multicultural Health Care or Health Equity Accreditation through 2026
OMAP, CHIP and OMHSAS	Increase organizational cultural and linguistic capacity to reduce health disparities	Increase 3% of MCOs providing culturally competent care through Consumer Assessment of Healthcare Providers and Systems (CAHPS) results or Mental Health Statistics Improvement Program (MHSIP) measures for BH	• OMAP: CAHPS ○ Child: ▪ In the last six months, how often was it hard to find a personal doctor who speaks your child's language? (Never) — MY 2020: 73.97% ▪ In the last six months, how often was it hard to find a personal doctor who knows your child's culture? (Never) — MY 2020: 74.70% • CHIP: Child CAHPS ○ Baseline metric, to be developed as this was a new	• OMAP: CAHPS: MY 2023 ○ Child: ▪ In the last six months, how often was it hard to find a personal doctor who speaks your child's language? (Never): 76.19% ▪ In the last six months, how often was it hard to find a personal doctor who knows your child's culture? (Never): 76.94% • CHIP: Child CAHPS: ○ TBD, once baseline is established • OMHSAS: MHSIP question: ○ Staff sensitive to culture/ethnicity MY 2023: 73%

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
			metric for MY 2022: ▪ In the last six months, how often was it hard to find a personal doctor who speaks your child's language? ▪ In the last six months, how often was it hard to find a personal doctor who knows your child's culture? • OMHSAS: MHSIP question: ○ Staff sensitive to culture/ethnicity MY 2022: 70.34%	
OMAP, OMHSAS, and OLTL	Increase organizational cultural and linguistic capacity to reduce health disparities	Increase 3% of MCOs providing culturally competent care through CAHPS results MHSIP measures for BH	• OMAP: CAHPS ○ Adult: ▪ In the last six months, how often was it hard to find a personal doctor who speaks your language? (Never) — MY 2020: 68.12% ▪ In the last six months, how often was it hard to find a personal doctor who knows your	• OMAP: CAHPS: MY 2023 ○ Adult: ▪ In the last six months, how often was it hard to find a personal doctor who speaks your language? (Never) — 70.16% ▪ In the last six months, how often was it hard to find a personal doctor who knows your culture? (Never) — 70.18% • OLTL: MY 2023: Overall satisfaction with health plan: 95% • OLTL: MY 2023: HCBS

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
			culture? (Never) — MY 2020: 68.14% • OLTL: overall satisfaction with health plan Aligned participants (Subpops 1&2) only rating the plan 8-9 or 10 (Q28) • Statewide 82.95% ○ AHC- 78.1% ○ KF- 82.6% ○ PHW- 78.8% ○ UPMC- 90.5% • OLTL: HCBS CAHPS, PCSP included all things important to you • Statewide- 65% ○ AHC- 66.0% ○ KF- 66.0% ○ PHW- 63.0% ○ UPMC- 66.0% • OMHSAS: MHSIP question: ○ Staff sensitive to cultural background (race, religion, language, etc.) Statewide MY 2022: 68.75%	CAHPS, Person Centered Service Planning (PCSP) included all things important to you: 72% • OMHSAS: MY 2023: MHSIP question: ○ Staff sensitive to cultural background (race, religion, language, etc.) ○ 2023: 71%
OMAP	Improve equity and cultural competence of care provided to beneficiaries by acute care hospitals	Number of providers who qualify by implementing REAL data collection and screening tools	OMAP • CY 2022: 86	OMAP • CY 2023: utilized REAL data collection for 25% of discharged PH-MCO members by hospitals that meet the criteria

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
	• **Directed Payment** ○ Address issues of racial and ethnic disparities by incentivizing hospitals to collect Race, Ethnicity, and Language (REAL) data, develop social needs and social risk screening processes — HQIP	Number of providers who qualify by developing a social needs and social risk screening process	OMAP • CY 2022: 2	OMAP • CY 2023: Maintenance of number of providers
Goal: Promote Efficient and Effective Use of Taxpayer Resources				
OMAP	Support alternative payment models that promote quality of care while managing increasing costs	Percentage of MCOs meeting contractual Value-Based Payment (VBP) requirements	OMAP • VBP percentage threshold: MY 2020 — all PH-MCOs met the 50% threshold, except one PH-MCO (7/8 = 87.5%)	OMAP • CY 2024: 100% PH-MCO meet the VBP percentage requirements
OMHSAS	Support alternative payment models that promote quality of care while managing increasing costs	100% of Primary Contractors to meet medical spend contractual VBP requirements by 2023	OMHSAS • 2019 baseline (23 of 25): 92% of Primary Contractors met VBP medical spend target	OMHSAS: CY 2023 • 100% — 24 of the Primary Contractors meet the medical spend target
OLTL	Support alternative payment models that promote quality of care while managing increasing costs	Establish contractual VBP requirements by 2023	OLTL • VBP percentage threshold: all CHC-MCOs meet 15% of medical spend in VBP and 7.5% of all LTSS spending in VBP	OLTL:CY 2023 • 100% of all CHC to meet the medical and LTSS spend targets

Office	Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (Year)
OMAP	Reduce the number of Potentially Avoidable Admissions (PAA) • **Directed Payment** ○ Reduce the number of PAA — HQIP	Number/percentage of hospitals that qualify for directed payment by reducing PAA percentage by at least 0.5% compared to CY 2022	OMAP • CY 2022: 36.65%	OMAP: CY 2023 • TBD
		Number/percentage of hospitals who qualify by attaining at least the 50th percentile compared to statewide average PAA in 2022	OMAP • 2021: 4.03% = 25th percentile benchmark (non-children's) 5.57% = 50th percentile benchmark (non-children's) and 8.42% = 50th percentile benchmark (children's only) • 2022: 3.98% = 25th percentile benchmark (non-children's) 5.76% = 50th percentile benchmark (non-children's) and 8.45% = 50th percentile benchmark (children's only)	OMAP: CY 2023 Each hospital will be measured and rewarded on: 1. Incremental improvement in reducing PAA (performance year compared to the prior year, base year) 2. Achieving benchmark performance at either the 25th or 50th percentile of the statewide PAA rate for non-children's hospitals 3. Children's hospitals are rewarded for achieving benchmark performance the 50th percentile of the statewide rate for children's hospitals
OMAP	Improve maternal health care by incentivizing high-quality care	Percentage of MCOs qualifying for perinatal and infant care benchmark bonus bundle payments for high-value care	OMAP • Two out of eight PH-MCOs qualified for a perinatal and infant care benchmark bonus bundle payment for high-value care (2/8 = 25%)	OMAP: MY 2023 • 57% PH-MCOs qualify for a perinatal and infant care benchmark bonus bundle payment for high-value care (one provider left since baseline data)

Framework for Quality Improvement

DHS embeds quality improvement activities throughout its cross-cutting programs, operations, and strategic initiatives. Through state-developed initiatives (including value-based purchasing requirements and directed payments), contractual requirements for its MCOs, performance improvement projects (PIPs), and other strategies, DHS drives quality improvement of its contractors to support its overarching goals and objectives.

State Initiatives that Support MCQS Goals and Objectives

Pennsylvania's managed care programs 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 ensuring value. 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.

- **Patient-Centered Medical Home (PCMH):** The purpose of the PCMH program is to promote and facilitate a medical home model of care that will provide better healthcare quality, improve self-management by participants of their own care and reduce avoidable costs over time.
- **OUD Centers of Excellence (COE):** A hub-and-spoke model focused on increasing access to MAT, integrating PH and BH services, and using Community-Based Care Management (CBCM) 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 for management of each individual's care. DHS will work with MCOs to explore value-based payment (VBP) arrangements for these providers in the future. This initiative supports engagement in treatment and recovery, adherence, SDOH supports, access to care, and reduced overdose rates.
- **ICWCs:** Modeled after the Certified Community Behavioral Health Clinic (CCBHC) demonstration funded by Substance Abuse and Mental Health Services Administration (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.
- **NF Quality Incentive Programs**: Incentive payments are designed to improve the quality of care, clinical care, and utilization in nursing facilities that fully participate in MA programs and demonstrate incremental improvements for year over year benchmarks. Incentive measures include National Quality Forum (NQF) measures (re-hospitalization, pressure ulcers, falls, flu and pneumococcal vaccines, and antipsychotic medication).
- **HQIPs:** Incentive payments are provided to hospitals, which achieve incremental improvement benchmarks or implement certain processes. Three 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 ED visit and a third to improve equity and cultural competence of care provided to beneficiaries by developing social needs and social risk screening processes.

- **SDOH:** DHS also has specific initiatives designed to address SDOH. The program agreements define SDOH as the "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes which can lead to inequities and risks." For over a year, DHS led a comprehensive stakeholder engagement process to assist in the development and adoption of a statewide strategy to address SDOH.
  - DHS has awarded funding to the Health Information Organizations (HIOs), who are in the process of procuring and implementing 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 (CBOs), 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 the use of CBOs. DHS requires its PH and BH MCOs to incorporate CBOs that address SDOH and reduce cost into innovative value-based models, and OMHSAS is working with its ICWCs to increase SDOH screenings. These interventions can improve health outcomes while decreasing health service utilization and costs.
- **VBP:** VBP is a DHS initiative to pay providers for the value of the services provided, rather than simply the volume of services. Value-based Purchasing strategies and VBP models are critical for improving quality of care, efficiency of services, and containing costs.
  - DHS is working on a Value-based Purchasing initiative to align the program offices. The guiding principles of this alignment include:
    - Promote efficient and effective use of taxpayer resources.
    - Improve quality of care.
    - Multi-payer alignment.
    - Meeting patients and providers where they are.
    - Promoting health equity.
  - One of the goals of this initiative is to define a common Value-based Purchasing framework with standardized strategies that most program offices can implement and operate by 2024. These strategies include Performance-Based Contracting, Shared Savings, Shared Risk, Bundled Payments, and Global Payments. A program may identify required and/or recommended Value-based Purchasing models specific to its service system needs that fit into the uniform framework. Another goal is to standardize Value-based Purchasing reporting requirements for MCOs and the evaluation process utilized by program offices. Currently, there is some level of reporting required of PH-MCOs, CHC-MCOs, and BH-MCOs, although there are significant differences across programs. Additionally, each program office does or will include VBP medical spend requirements in the agreements with its Primary Contractors/MCOs.
  - OMAP and OMHSAS require the PH-MCOs and BH-MCOs, respectively, to have a portion of their Value-based Purchasing strategies incorporating the use of CBOs to address SDOH domains, with the view that the support CBOs provide will contribute to improved health outcomes.
  - OMAP administers a maternity care bundled payment, which covers all prenatal, labor and delivery, postpartum, and infant healthcare services provided by a maternity care team comprised of varying provider types, including doulas. This bundled payment also includes an opportunity to earn additional incentive payments for performance on various quality measures.
  - OMHSAS requires Primary Contractors and their BH-MCOs to participate in the Standardized Transitions to Community (TC) Value-Based Purchasing (VBP) model. The TC Model is a structure that standardizes performance measures to better support care transitions from psychiatric inpatient (IP) discharge to community-based services across the entire healthcare system. Requirements include (1) standardized performance measures tied to payment for IP Providers and (2) standardized data collection for outpatient (OP), Behavioral Health Home Programs (BHHP), and Case Management VBP models to link natural pathways of care that can structure standardization of attribution for VBP arrangements. The required standardized measures are Follow up after Hospitalization (FUH) for mental illness, which identifies the percentage of members

who received follow-up within 7 days and 30 days of discharge and the PA Specific Readmission measure, which is the percentage of acute inpatient stays for psychiatric care with subsequent readmission to inpatient acute psychiatric care within 30 days of the initial inpatient acute psychiatric discharge.

- **P4P**: P4P is a value-based purchasing arrangement that 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/Primary Contractors focusing on improving care for those with serious persistent mental illness (SPMI). 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, including health equity measures.
  - HC PH offers an MCO P4P program. OMAP chooses P4P quality measures based on an analysis of past data indicating the need for improvement across the HC program as well as the potential to improve health care for a broad base of the HC 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. This additional benchmark payout is referred to 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 has incorporated five health equity measures into the PH-MCO P4P program.
  - 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.
  - CHC has seven CHC-MCO P4P measures. All seven have benchmark incentive payments and incremental improvement incentive payments (using a benchmark year of 2021, measurement in 2022 and payment in 2023), but there are no penalties at this time. Measures include NCQA and Pennsylvania Performance Measures (PAPMs) around assessments, care plans, reassessments and planning after discharge, sharing care plans with the members' PCPs, CAHPS health plan satisfaction and HCBS results and nursing home transitions.
  - HC BH offers a P4P program. OMHSAS selected key HEDIS and a Pennsylvania Performance Measure (PAPM) performance measurements for its P4P program. Performance goals are based on HEDIS percentile benchmark performance and improvement performance goals for all the Primary Contractors. The P4P program measures Benchmark Performance and Improvement Performance. The Primary Contractors have an opportunity to earn a Benchmark Performance payout for three performance measures when they meet the designated target. Incremental performance payouts are measured by comparing rates from the previous measurement year.
  - In 2024, HC BH will offer a Health Equity P4P. OMHSAS analyzed available data for all three P4P performance measures. There was a statistically significant difference in the Follow-up after Hospitalization (FUH) rates for African-American members compared to the total population for the past four years. The Primary Contractor is eligible for a Health Equity Performance payout for the improvement of the HEDIS 7- & 30-Day FUH rates of the African American/Black population. Primary Contractors who improve the Follow-up after Hospitalization for mental illness for 7 and 30 Days from the baseline rate for the African American/Black population by ≥2% will receive an incentive payment. Primary Contractors with less than a 2% improvement will not receive a payout.
  - 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.
  - Because of the size of its program, ACAP does not include P4P incentives.
  - DHS is well positioned to participate in value or outcomes-based arrangements with manufacturers of high-cost or high-impact drugs or biologics.
    - DHS has been in conversations with the manufacturers of pipeline gene therapies regarding potential outcomes-based rebate arrangements.
    - The single preferred drug list (PDL) structure ensures that any value or outcomes-based rebate arrangements will apply to the MCO utilization as well as any FFS utilization.

    - The PH-MCO program is structuring a non-risk arrangement for high-cost gene therapies for hemophilia and beta thalassemia. The non-risk arrangement will ensure that members of all PH-MCOs will have equivalent access to life changing therapies. In addition, DHS will have the opportunity to closely monitor the utilization and outcomes associated with each of the new therapies.
- **Directed Payments:** DHS has a number of CMS-approved directed payments that support the advancement of its goals and objectives to ensure access, improve population health outcomes, and ensure appropriate fiduciary responsibility of taxpayer resources. Below is a brief summary of the state's directed payments, which have associated objectives and metrics included in this MCQS:
    - Inpatient and outpatient hospital access.
    - Reduce the number of potentially avoidable admissions — HQIP.
    - Increase initiation and engagement in OUD treatment following an ED visit — HQIP.
    - Increase length of engagement in treatment for SUD through counseling and MAT.
    - Increase access to care through use of ICWCs.
    - Preserve access to PDN services for members under the age of 21.
    - Preserve access to emergency transportation services for members residing in and near the City of Pittsburgh and Philadelphia.
    - Address issues of racial and ethnic disparities by incentivizing hospitals to collect Race, Ethnicity, and Language data, develop social needs and social risk screening processes, and develop a community advisory board with a focus to reduce avoidable admissions due to focus on vulnerable population of racial and ethnic minorities — HQIP.
    - Improve quality for nursing facilities by incentivizing clinical quality care in facilities and statewide learning network participation of nursing facility staff.
    - Preserve access and maintain network adequacy for nursing facility services and support nursing facility increased staffing requirements.

Quality Management Program

DHS requires MCOs to develop a written quality management program description, evaluation and work plan to ensure accessibility, availability, and quality of care being provided to its members. The MCO must then develop and implement policies, procedures, and processes that are consistent with the MCQS, such as:

1. An annual program description that documents the MCO's monitoring strategy across all services, all treatment modalities, and all sub-populations.
2. 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 Data, HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Mental Health Statistics Improvement Program (MHSIP), Consumer and Family Satisfaction Team Survey (C/FST), Medicaid Adult Core and Medicaid/CHIP Child Core, NF measures, PA-specific Performance Measures (PAPMs), , PIPs, and other data requested by DHS.
3. A work plan and timetable for the coming year that clearly identifies target dates for implementation and completion of all phases of all quality management activities, including, but not limited to:
    a) Data collection and analysis.
    b) Evaluation and reporting of findings.
    c) Implementation of improvement actions where applicable.
    d) Individual accountability for each activity.

DHS requires that each of the MCO's 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. 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. In accordance with 42 CFR § 438.236, 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. For example, the PH-MCO Agreement requires PH-MCOs to implement and maintain an opioid use disorder/substance abuse disorder (OUD/SUD) strategy for its members with OUD/SUD, including initiatives similar to the below guidelines:

- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016; 65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1
- The Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Non-Cancer Pain. Accessed January 31, 2017, https://www.health.pa.gov/topics/Documents/Opioids/Non-cancer%20Pain%20Guidelines%20Final.pdf

Member and Provider Satisfaction

Member perspective provides important information about how the program is working to improve member health and whether services are accessible. 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:

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

DHS requires that PH, CHC, and CHIP-MCOs:

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

OMHSAS conducts the MHSIP, C/FST and provider surveys to ascertain member and provider satisfaction with network services.

1. The Consumer/Family Satisfaction Team survey questions address satisfaction with the Provider(s) and the mental health and drug and alcohol service(s) members are receiving. The face-to-face surveys occur at least annually.

2. OMHSAS requires the Primary Contractor, either directly or via its BH-MCO to have systems and procedures to assess Provider satisfaction, to include, but not be limited to, an annual Provider satisfaction survey. Areas of the survey must include claims processing, Provider relations, credentialing, Prior Authorization, Service Management and Quality Management.

3. The MHSIP survey is a nationally used survey and measures concerns that are important to consumers of publicly funded mental health services. The survey is required by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is administered by the Office of Mental Health and Substance Services (OMHSAS). This survey is distributed annually in the spring to a sample of individuals who received at least one Mental Health service during the prior year. The survey populations consist of Adult/Peer Services and Family/Child recipients, with each category receiving its respective survey.

For each of the MCOs, DHS staff review grievance and appeals logs and reports on a regular basis. DHS also performs regular reviews of the MCO grievance and appeals processes. The findings that are

developed are communicated directly to the MCO and are shared with DHS contract managers. In addition, data from the reports are used in MCO Comparative Reporting and other types of public reports.

DHS requires all PH and CHC-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.

Performance Improvement Projects

Consistent with 42 CFR § 438.330(d), DHS requires its contractors to conduct performance improvement projects (PIPs) to achieve sustained improvement in health outcomes and beneficiary satisfaction as well as access, quality, and timeliness of care.

Each MCO and BH Primary Contractor assess the problem statement and goal and analyze their data to create a plan proposal. For HC BH, 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 2019, which will run through at least 2024. The HC PH and HC BH programs are conducting PIPs regarding opioid/substance use disorder (SUD) treatment.

1. OMAP is studying preventing inappropriate use or overuse of opioids.
2. OMHSAS is studying SUD/opioid treatment access, engagement in treatment, and increasing the SUD counseling component along with the pharmacological component of Medication-Assisted Treatment (MAT) and developing population prevention strategies while addressing racial and ethnic health disparities.

OMAP also has implemented a PIP that focuses on reducing preventable admissions and readmissions and ED visits. OMAP will continue PIPs with the same two focus areas (preventable admissions, readmissions, and ED visits; and preventing inappropriate use or overuse of opioids) beginning in 2023.

The OMHSAS PIP cycle will extend from January 2021 through December 2024 with initial PIP proposals submitted in 2020 and the final report due in September 2025.

CHIP's PIPs focus on improving access to pediatric preventive dental care and improving blood lead screening rate in children. The CHIP cycle will run from 2021–2023, with 2021 as the baseline year and final reports due in 2024.

CHC PIPs focus on care coordination and community transitions. PIPs for CHC were rolled out along with the regional rollout of CHC and baseline years were 2019 (SW), 2020 (SE), and 2021 (L/C, NE, NW). All were extended through at least the end of 2023.

ODP's PIP runs through 2023 and concentrates on decreasing social isolation among ACAP members.

Table 4 provides a summary of DHS-required PIP topics, aims and interventions and the contractors required to implement those PIPs.

Table 4.

PIP Topic	PIP Aim	PIP Intervention	Programs
Opioid/SUD Treatment	Preventing inappropriate use of opioids.	MCOs developed strategies focused on four common objectives: opioid prevention, harm reduction, coordination/facilitation into treatment, and increased MAT utilization. Interventions must include strategies to remediate race and ethnicity barriers.	OMAP
	Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and addressing racial and ethnic health disparities through a systematic and person-centered approach.	• MCOs were required to develop strategies to: ○ Increase access to appropriate screening, referral, and treatment for members with an opioid and/or other SUD. ○ Improve retention in treatment for members with an opioid and/or SUD diagnosis. ○ Increase concurrent use of Drug and Alcohol counseling in conjunction with Pharmacotherapy (MAT). ○ Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH Contracting networks.	OMHSAS
Preventable Hospital Utilization	Reducing potentially preventable hospital admissions and readmissions and ED Visits.	MCOs developed strategies to reduce potentially avoidable ED visits and hospitalizations, including admissions that are avoidable and readmissions that are potentially preventable. Interventions must include strategies to remediate barriers disproportionately experienced by certain racial and ethnic groups.	OMAP
Access to Pediatric Preventive Dental Care	Positively affect member health outcomes or experiences of care related to accessing pediatric preventive dental care.	MCOs were required to develop interventions to improve access to pediatric preventive dental care, including: report on the ADV HEDIS measure; collect and report a rate for the total eligible members receiving preventive dental services and develop a third indicator/aim beyond those specified by CHIP.	CHIP

PIP Topic	PIP Aim	PIP Intervention	Programs
Blood Lead Screening	Positively affect member health outcomes or experiences of care related to blood lead screening.	MCOs were required to develop interventions to improve blood lead screening rates in children, including: report on the Lead Screening in Children HEDIS measure; collect and report a rate for the total number of children successfully identified with elevated blood lead levels and identify and define at least 1 additional topic-related performance measure to collect and study.	CHIP
Care Coordination	Strengthen care coordination to assure optimal transition of care from the hospital to home or nursing home.	MCOs were required to implement interventions to improve care coordination for participants being discharged from the hospital .	OLTL
Nursing Home Transitions	Improve transition of care from the NF to the community.	MCOs were required to implement interventions to improve transitions from nursing facilities to the community.	OLTL
Reduce Social Isolation	Reduce social isolation of adults with autism by establishing socially valued roles through Person Centered Planning.	The intervention features a person-centered social role valorization model that sets goals for attaining socially valued roles. Intervention tracking measures center on measurement using a Goal Attainment Scale. Two performance indicators are based on the social isolation tool: a Social Isolation Index score which measures the average social isolation of ACAP members, and the percentage of members reporting feeling socially isolated.	ODP

DHS requires its 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. Results of the analysis can be found in the annual EQRO reports: https://www.pa.gov/en/agencies/dhs/resources/medicaid/managed-care-quality-strategy.html

Performance Measures

The DHS Program Offices use a combination of national performance measures and Pennsylvania specific measures for program monitoring. National performance measure stewards include NCQA's HEDIS set, National Quality Forum (NQF) measures, and CMS Core Sets, including Adult, Child, and BH.

In addition to national measures, MCOs collect 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.

DHS evaluates its performance on these measures and uses that information to inform the development of its MCQS goals and objectives. This includes a review of CMS Core Set measure performance compared to national norms, as well as Pennsylvania-specific trends. As discussed in this strategy, the impact of the COVID-19 pandemic on many measures has made underlying root cause analysis of performance challenging for 2020 and 2021. In addition, developing reasonable measure targets is challenging as workforce and supply chain impacts, as well as changes in how care is delivered, will likely persist beyond the end of the PHE. However, DHS has identified certain measures that it believes are particularly impacted (such as hospital and ED utilization) and has focused strategies to return access to pre-pandemic levels. Once the pandemic's impact on measures has stabilized, DHS will be able to refocus its improvement targets based on measure performance.

The EQRO evaluates the state performance on quality measures, including LTSS specific measures, and DHS posts its measures and performance outcomes on its website for public review: https://www.pa.gov/en/agencies/dhs/resources/medicaid/managed-care-quality-strategy.html.

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".[4] As in many states, health disparities are a serious issue in Pennsylvania. As such, in 2019, DHS added a section in its Strategic Plan to promote health equity. This sets a collective vision moving forward as a Department, with each program office playing a role.

For the past several years, OMAP shared identified health disparities with the PH-MCOs, but disparities have persisted. As a result, OMAP began linking a percentage of the MY2020/RY2021 MCOP4P program payment to improving outcomes for the African American population, starting with an incremental improvement payout for prenatal care in the first trimester and well-child measures for care rendered in 2020. In MY2021/RY2022, OMAP added two chronic condition quality measures, Controlling High Blood Pressure and Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), and postpartum care to the MCO P4P health equity program. For MY2022/RY2023 OMAP added all five of these measures to its Provider P4P program, and for MY2021/RY2022 a health equity component was added to the Maternity Care Bundle program. This program incentivizes performance on seven MCO P4P measures: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment, Timeliness of Prenatal Care, Postpartum Care, Prenatal Depression Screening and Follow Up, Postpartum Depression Screening and Follow Up, Prenatal immunization status, Well child visits (Modified HEDIS®): Children who receive two (2) or more well-child

[4] Disability status is determined through the Office of Income Maintenance and, for these purposes, means an individual qualified for MA based on this determination.

visits with a primary care physician within the first sixty (60) days after birth. For MY 2022, CHIP-MCOs were required to report on race and ethnicity for two HEDIS measures, Child and Adolescent Well-Care Visits (WCV) and Prenatal and Postpartum Care (PPC). OMAP is focusing on these areas due to high areas of disparities and opportunities to improve the overall health of African American members. In 2023 and ongoing, OMAP will evaluate disparities and if any additional measures should be added, including disparities for the CHIP population. OMAP also established a directed payment for acute care hospitals that is designed to incentivize the creation of pathways to improve health equity and address issues of racial and ethnic disparities. This initiative provides financial incentives for hospitals to collect Race, Ethnicity, and Language data, develop social needs and social risk screening processes, and develop a community advisory board comprised of internal and external stakeholders.

In 2021, OMAP and OLTL added language into the agreements that required PH and CHC-MCOs to either achieve, or be working towards, the attainment of the NCQA distinction in Multicultural Health Care, or its successor, the Health Equity Accreditation. OMHSAS added the same requirement for BH-MCOs for 2022. All PH, CHC and BH MCOs have obtained the NCQA distinction in Multicultural Health Care or Health Equity Accreditation.. 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 all PH-MCOs have achieved this designation. Two BH-MCOs have received the Health Equity Accreditation, while all other BH-MCOs have attained the Distinction in Multicultural Health Care. OMAP and OMHSAS have 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. Starting in 2022, BH-MCOs were required to stratify their complaints, grievances, denials, and penetration rates by race and ethnicity to identify potential inequities.

OLTL is assessing its available data to start measuring disparities. OLTL has identified Functional Eligibility Determination (FED) assessments, claims data, HCBS CAHPS and HEDIS measures as several data sources that could be used to identify disparities, and will begin analysis in 2024.

Efficiency Adjustments

Medical efficiency analyses are value-based strategies that emphasize areas for improvement in MCO program management. This is accomplished through evidence-based approaches that identify potentially preventable events or avoidable health care costs within medical services. Preventable services such as inpatient admissions/readmissions, low acuity non-emergent ED visits, pharmacy, high cost radiology, inappropriate Caesarian sections, and others are targeted for cost savings. Cost savings are realized as this inefficient care is not included in the buildup of the capitation rates. Not funding inefficient care in the capitation rates also incentivizes innovative MCO initiatives aimed to improve health outcomes for Pennsylvania MA enrollees. MCOs can improve their financial position 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 and CHIP 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.

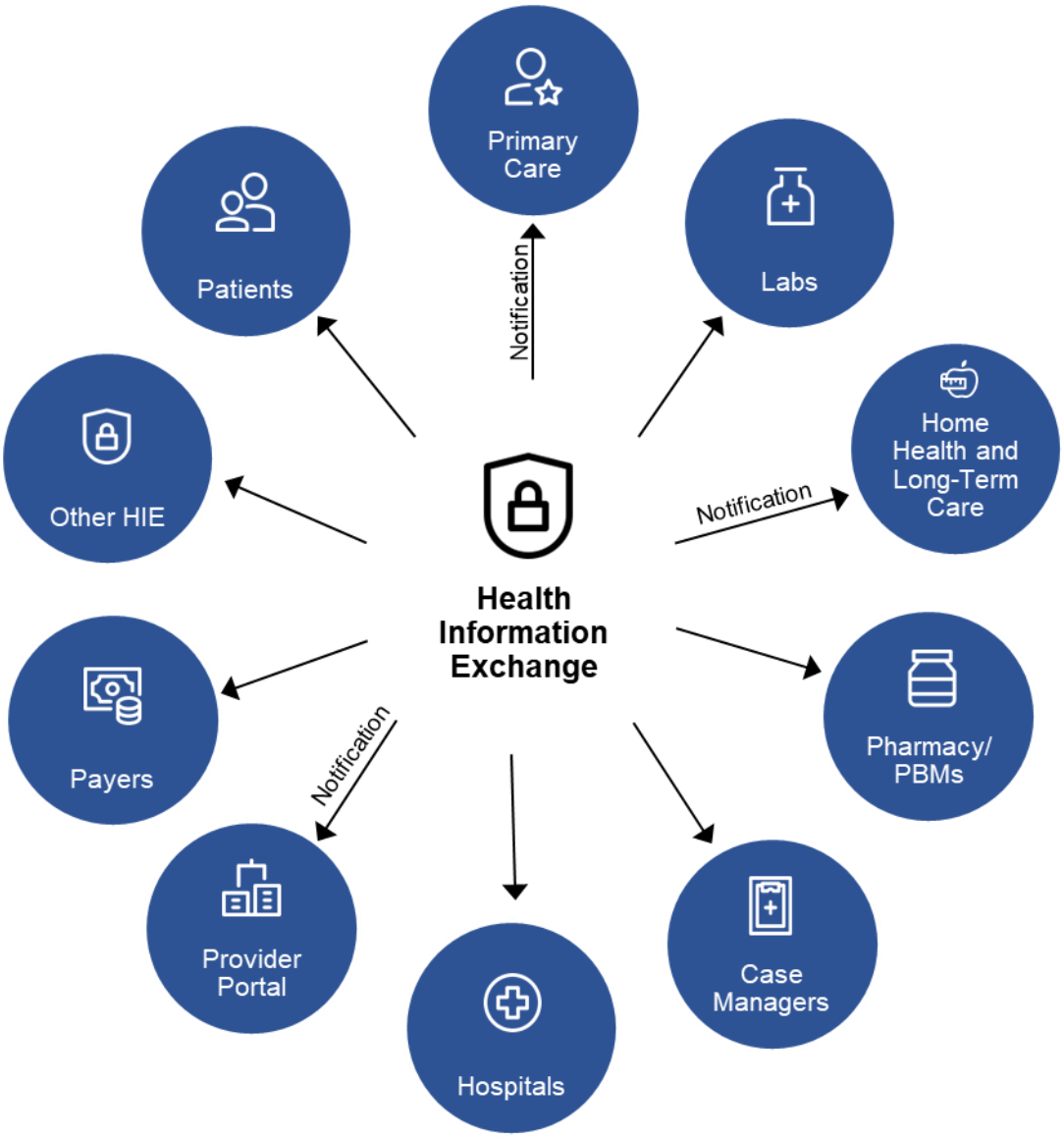
DHS realizes that real-time patient level clinical data is necessary to advance its quality strategy and improve utilization of services. Hospitals, care providers, and payors must become meaningful users of electronic health records (EHRs) to have access to complete and timely information for quality decision making, improve the efficiency of care delivery and reduce redundancy. Electronic record usage was encouraged through the Medicaid and CHIP 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 Pennsylvania eHealth Partnership Program, in OMAP, promotes this effective data transfer through a federated statewide Health Information Exchange (HIE). The HIE, through the PA Patient & Provider Network (P3N), works to ensure interoperability and interconnectivity across all entities. The P3N consists of Pennsylvania certified Health Information Organizations (HIOs), Pennsylvania Department of Corrections, and neighboring state HIEs. 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. PH, BH and CHC MCOs are required to contract with at least one HIO that is capable of connecting to P3N. These MCO/HIO connections are essential for supporting real-time health care encounter alerting, with more than 150 hospitals sending real-time admission, discharge, and transfer (ADT) messages to the P3N ADT Service. MA MCO can also use the HIO clinical data repository for quality reporting, with at least two P3N HIOs offering primary source medical record information through the new NCQA Data Aggregator Validation certification program. MA PCMHs are also required to be connected to a P3N Certified HIO.

The new P3N includes a statewide care plan registry which will host MA Obstetric Needs Assessment Forms (ONAFs) and Department of Aging Area Agencies on Aging SAMS Care Plans. As referenced on Page 28, the statewide P3N HIE infrastructure will be integrated with a statewide resource and referral tool to support SDOH needs assessments and closed-loop referrals for health related social needs.

Figure 5. HIE Schematic



Managed Care Standards and Requirements

Network Adequacy

Each managed care program agreement entered into by DHS identifies network adequacy standards for those programs that ensure covered standards are available and accessible to members. These standards are consistent with state regulations and must comply with CMS network adequacy standards as outlined in 42 CFR §§ 438.68 and 438.206 (and, as applicable to CHIP, 42 CFR §§ 457.1218 and 457.1230[a]).

DHS instituted network adequacy requirements consistent with federal regulations when the HC PH program was designed and implemented in 1997. The expected size of the MA population was considered in conjunction with MA historic utilization data from the MA FFS Program to identify provider/specialty-provider requirements and access needs. MA beneficiary shopping patterns and geographic locations of providers were part of the assessment process. That process has been refined over the years as HC PH matured and expanded Commonwealth-wide. As new zones of operation were implemented, OMAP again reviewed utilization data and assessed the geographic location of the licensed provider types from the

licensure files kept by the Pennsylvania Department of State.

Today, OMAP and its enrollment assistance contractor collect a weekly automated provider file from the HC PH-MCOs. This file feeds a web-based network geography program that uses the HC Standard Agreement network adequacy requirements to portray a geographical access result for each MCO. OMAP Contract Teams then review the network geography for each MCO within the Medicaid Enterprise Monitoring Module (MEMM) to identify areas of weaknesses or adequacy concerns. The Contract Teams can also use MEMM to develop and conduct direct provider outreach campaigns to assess the accuracy of MCO provider information submitted with the weekly files. When areas of inadequacy or weakness are identified, the Contract Teams work with the MCO to implement improvement initiatives, or apply formal sanctions such as Corrective Action Plans (CAPs).

CHIP-MCOs provide monthly provider network files to the CHIP contractor, and the monitoring system is updated to show the status of member travel times for certain providers, with follow-up for identified issues. GeoAccess maps are provided at least annually and upon request. OLTL assessed initial compliance with network adequacy upon CHC implementation and uses GeoAccess reports to assess adequacy on an ongoing basis. In addition, OLTL analyzes and addresses individual complaints regarding provider access and is preparing to monitor PH and dental providers using a call campaign. ODP reviews compliance with network standards as part of annual monitoring. OMHSAS oversight and monitoring of networks includes a review of GeoAccess maps using member level data detailing travel distance to provider types in the network, utilization data, complaints, and monitoring reports of access issues. MCOs are contractually required to resolve failure to comply with access standards, including the submittal of CAPs and, potentially, sanctions for failure to implement the CAPs.

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. These requirements vary by provider type and population. 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.

In compliance with the Managed Care Final Rule, DHS has established time and distance standards for certain providers, as well as other timely access standards where appropriate. These standards are located within the MCO contracts for the programs and are summarized below.

Table 5 and Table 6 outline required time and distance standards for providers, by geographic location.

Table 5.

Network Time/Distance Standards Urban = 30 min Rural = 60 min	CHIP	ODP	OLTL	OMAP	OMHSAS
Adult Primary Care	✓	✓	✓	✓	
Pediatric Primary Care	✓			✓	
Certified Nurse Midwives and Certified Registered Nurse Practitioners		✓	✓	✓	
Ambulatory Services (OB/GYN and LTSS standards under ODP only)		✓			✓
Hospitals	✓		✓	✓	
Inpatient and Residential Services (LTSS standards under ODP and OLTL only)		✓	✓		✓
Federally Qualified Health Center (FQHC) *(For FQHC BH Services – OMHSAS)			✓		* ✓
Rehabilitation Facilities	✓		✓	✓	
Rural Health Clinic (RHC)			✓		

Table 6.

Network Time/Distance Standards Urban = 30 min Rural = 60 min	CHIP	ODP	OLTL	OMAP	OMHSAS
Specifically Identified Specialists:					
General Surgery	✓	✓	✓	✓	
Obstetrics & Gynecology	✓	✓	✓	✓	
Oncology	✓	✓	✓	✓	
Physical Therapy	✓	✓	✓	✓	
Radiology	✓	✓	✓	✓	
Cardiology	✓	✓	✓	✓	
Pharmacy	✓	✓	✓	✓	
Orthopedic Surgery	✓	✓	✓	✓	
General Dentistry	✓	✓	✓	✓	
Pediatric Dentistry	✓	✓	✓	✓	
Dental Anesthesiology	✓	✓	✓	✓	
Oral Surgery	✓	✓	✓	✓	
Nursing Facility	✓	✓	✓	✓	
Dermatology	✓	✓	✓	✓	
Urology	✓	✓	✓	✓	
Neurology	✓	✓	✓	✓	
Otolaryngology	✓	✓	✓	✓	

Table 7 and Table 8 summarize contractual standards other than time and distance, including standards for LTSS providers.

Table 7.

Required Minimum for Choice of Providers (within time and distance standards)	CHIP	ODP	OLTL	OMAP	OMHSAS
Adult Primary Care	2	2	2	2	
Pediatric Primary Care	2			2	
BH Providers	2	2			2
LTSS Providers		2	2		
Hospitals	1		1	1	
MHIP Hospital					1
Rehabilitation Facilities *(at least 1 in the Health Choices/CHC Zone)	2		*2	*2	
Dental Care (Anesthesiology)	2		2	2	
FQHCs and RHCs *(Located within each HC zone and willing to accept PPS rates)			*All	*All	*All

Table 8.

Required minimum for choice of Providers (within time and distance standards)	CHIP	ODP	OLTL	OMAP	OMHSAS
Pediatric Specialists Oral Surgery Nursing Facility Dermatology Urology Neurology Otolaryngology *(1 within time and distance standards and a 2nd within the CHIP zone)	*2				
Specifically Identified Specialists: General Surgery Obstetrics & Gynecology Oncology Physical Therapy Radiology Cardiology Pharmacy Orthopedic Surgery General Dentistry Pediatric Dentistry Oral Surgery Nursing Facility Dermatology Urology Neurology Otolaryngology		2	2	2	

Established appointment wait time standards for emergent and urgent conditions, routine appointments, assessments/first examinations, and other specific types of care, including some specialized standards by population requirements are outlined in Table 9.

Table 9.

Appointment Wait Time Standards

General (CHIP, OLTL & OMAP)	Specialty (CHIP, OLTL & OMAP)	Maternity (CHIP, OLTL & OMAP)	Behavioral Health (CHIP & OMHSAS)	ACAP (ODP)	EPSDT & HIV/AIDS (OMAP)
Emergency Medical Conditions - Seen immediately or referred to emergency facility	**Emergency Medical Conditions** - Seen immediately or referred to emergency facility	**Emergency Services** - Immediate	**Emergency Crisis Services** - Within 1 hour for emergencies	**Emergency Medical or Behavioral Conditions** - Seen immediately or referred to emergency facility	**Initial EPSDT Screening** - Scheduled within 45 days from Enrollment date
Urgent Medical Condition - Scheduled within 24 hours	**Urgent Medical Condition** - Scheduled within 24 hours	**Initial Prenatal Care** - First trimester: within 10 business days of member being identified as pregnant	**Urgent Medical Condition** - Scheduled within 24 hours	**Urgent Medical or Behavioral Condition** - Within 24 hours of the Request for PCP and Behavioral Specialist Services -Within 24 hours of the referral for all other services	**Initial HIV/AIDS Care** - Scheduled within 7 days from Enrollment date
Routine Care - Available within 10 business days of member request	**Routine Care** - Available within 15 business days of member request for: Otolaryngology Orthopedic Surgery Dermatology *Certain Pediatric Specialties (CHIP & OMAP only)	**Initial Prenatal Care** - Second trimester: within 5 business days of member being identified as pregnant	**Routine Care** - Available within 7 business days	**Routine Care** - Within 7 days of member request for PCP -Within 7 days of referral for all other services	
Non-Urgent Sick Visits - Scheduled within 72 hours of request (OLTL only)	**Routine Care** - Available within 10 business days of member request for specialties not listed above (CHIP & OMAP only) - Scheduled to occur within 30 days for all Community Health Choices specialty types (OLTL only)	**Initial Prenatal Care** - Third trimester: within 4 business days of member being identified as pregnant		**Initial Physical Exams** - Scheduled within 3 weeks of enrollment and annually thereafter	
Initial Health Assessment/Physical Exams/First Exams - Scheduled within 3 weeks of enrollment (CHIP & OMAP only)		**Initial Prenatal Care** - High-risk pregnancies: within 24 hours of member being identified as high risk			

Some office contracts outline opportunities for exceptions to the network adequacy standards.

- OMAP and OLTL require PH and CHC-MCOs to make services accessible within the required travel times using out-of-network providers if in-network providers are not available.
- OMHSAS and ODP require approval by OMHSAS or ODP for exceptions when the contractor determines that a member requires a specialized service and a network provider is not available in the required time frames. The network exception request must provide for the appropriate delivery of services and the availability of local supports for the member and the request is evaluated based on the number of network providers in the service area, on a case- by-case basis.

As noted, DHS agreements with program contractors ensure compliance with state regulations as well as the CMS network adequacy standards as outlined in 42 CFR §§ 438.68 and 438.206 (and, as applicable to CHIP, 42 CFR §§ 457.1218 and 457.1230[a]).

Credentialing

The HC 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, CHC and CHIP 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 HC 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 P&T Committee meetings are open to the public. DHS and its PDL vendor monitor each MCO's performance in adherence to the PDL through regular analysis of reported encounter data.

Transition of Care Policy

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, DHS's Enrollment Assistance Contractor (EAC) 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. OLTL uses an independent enrollment broker, which helps beneficiaries with their CHC-MCO enrollment. Because there is only one BH-MCO per county, an EAC or enrollment broker is not needed for BH-MCO enrollment and members are enrolled in their BH-MCO shortly after eligibility determination. 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 BH condition when they transfer from the MA FFS Program to an MCO, between MCOs, and from an MCO to FFS. These procedures address continuity of prior authorized services for adults; and continuity of "clinically appropriate course of treatment" plans for children and adults. These procedures are captured in the following MA Bulletins:

- MAB 99-03-13
- MAB 99-96-01

Additional details are provided in the attachments to MA Bulletin 99-03-13:

1. Attachment A — Procedure for Continuity of Prior Authorized Services for Adults — Transition from Fee-for-Service to a Managed Care Organization

2. Attachment B — Procedure for Continuity of Prior Authorized Services for Adults — Transition from a Managed Care Organization to Fee-for-Service
3. Attachment C — Procedure for Continuity of Prior Authorized Services for Adults — Transition from an MCO to an MCO
4. Attachment D — Procedure for Continuity of Care for Course of Treatment Services Not Requiring Prior Authorization for Adults Age 21 and Older and Children Under the Age of 21

These requirements generally require continuity, at the beneficiary's option, of authorizations for the amount, duration/frequency, and scope of services, for up to 60 days or pending a concurrent clinical review (or, in the case of pregnant members, through postpartum care). In addition to these requirements, Pennsylvania law (Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §991.2117), 28 Pa. Code § 9.684 and 31 Pa. Code § 154.15 require continuity for ongoing courses of treatment for up to 60 days, and extended as clinically appropriate, and pregnancy care in the second or third trimester through postpartum care.

In addition, the PH-MCOs and ACAP are contractually required to implement a transition of care policy that complies with 42 CFR § 438.62(b)(1)(which includes referral to network providers and exchange of historical utilization information). CHIP MCOs are required to implement a transition of care policy compliant with 42 CFR § 438.62 (b) (1) (2) (3) and 42 CFR § 457.1216.

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.

Other Standards

As part of its contractual monitoring approach outlined in this document, DHS staff monitor compliance with all standards included in the agreements with the MCOs, including all the required components of 42 CFR Part 438, subpart D. However, below are details regarding certain standards that bear mention.

Identification of Special Needs and Persons who Need LTSS

In the HC PH 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 EAC 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 HC 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 ED 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 HC members. Representation on this Committee must include, but not be limited to, women, minorities, and persons with special needs and at least one person with expertise on the medical needs of children with special needs. Provider representation includes PH, BH, and dental health providers.

In the HC BH program, services are adapted to meet the special needs of people with mental illness who are also 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. The continuum of services allows individuals who have special needs to maintain the highest level of independence in the community. 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 age 21 or older who have both Medicare and Medicaid or who 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.

For individuals who seek MA coverage for LTSS, an Independent Enrollment Broker (IEB) facilitates the eligibility process for individuals seeking LTSS under CHC. 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. Concerning 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 Home Care Assessment 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, strengths, and preferences. DHS 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, as well as continued compliance with the quality assurance requirements of 42 §§ CFR 441.302(a)–(c), 441.303(a)–(e), 441.715(a), and 441.745(b). Using both the early launch and steady state approach allows DHS to coordinate its approach in each cycle affecting 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: https://www.pa.gov/en/agencies/dhs/resources/medicaid/chc/chc-evaluation-plan.html.

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 EAC or 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 of ongoing improvement processes https://www.pa.gov/en/agencies/dhs/resources/medicaid/managed-care-quality-strategy.html. 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.

Oversight of MCOs

Monitoring

The 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. DHS personnel oversee these requirements on a regular basis, in part using the MEMM. 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.

DHS collects HEDIS measures on an annual basis from the MCOs. 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 reports that DHS collects from and discusses with each MCO. These reports are an opportunity to:

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

DHS monitors the day-to-day operations of the 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 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 (Note: CHIP does not have specific contract managers assigned to each MCO but rather utilizes Quality Assurance analysts for the overall oversight of the CHIP MCOs). These other staff include individuals who focus on financials, systems, grievance and appeals, special needs,

clinical matters, 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, OMHSAS, OLTL, and CHIP use an electronic Systemic Monitoring and Access Retrieval Technology (SMART) tool 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 noncompliance 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's contract manager tracks and monitors the MCO's adherence to this CAP until the problem is resolved.

One hundred and seventy-two Standards are reviewed to determine compliance with federal and state requirements over a rolling three-year period. The review includes an on-site visit with individual Primary Contractors or MCOs. Following the visit and desk review of Standards, 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 progression of their processes to improve the reviewed 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, OMAP conducts on-site visits and holds a "360" meetings with each individual MCO to review all major operational aspects, outcomes, and priorities. 360s provide an opportunity for OMAP to ascertain the progress each MCO is making in meeting quality goals and review quality initiatives. 360ss also allow OMAP to identify and share best practices as well as information obtained from interactions with CMS, and other state managed care programs. While the 360 meeting structure is a new approach specific to OMAP, all other program offices within DHS also conduct on-site visits and hold quarterly quality review meetings and other monitoring meetings with each plan. DHS will evaluate the productivity of the 360 meeting structure and expand it to other programs if warranted.

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, required timeframes for calculation, and reporting.

Medicaid Enterprise Monitoring Module

Medicaid Enterprise Monitoring Module (MEMM) 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 and CHIP programs, MCO operations, and provider network compliance. It includes dashboards for Access to Care, Provider Network Submissions, Provider Negotiations and Terminations, Provider Network Adequacy, SMART, and more.

MEMM 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 10 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. ODP does not utilize a program oversight portal such as MEMM at this time; their methodologies for ensuring compliance with all contractual standards, including network adequacy, are discussed earlier in this document. OMHSAS is in the process of migrating to MEMM.

Table 10. MEMM Application by DHS Programs

Application	HC PH	CHC	CHIP	HC BH
MCO Oversight Dashboard	X	X	X	X
Network Adequacy	X	X	X	X
HCBS Network Adequacy		X		
Negotiations and Terminations	X	X		
SMART	X	X	X	X
MATP	X			
Provider Network Analytics	X	X	X	X
Access to Care	X	X		
Provider Enrollment FFS	X			X
Key Performance Measures	X	X	X	X
Care Management	X			
CAHPS	X	X	X	
HEDIS	X	X	X	
Member Level Data	X	X		X
FQHC Rate Manager	X		X	
Network Geography	X			X
Integrated Quality Dashboard	X	X	X	
PAPM	X	X		
Submission Metrics Dashboard			X	X
Provider Search Dashboard			X	X

Sanctions

When a 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:

1. Fails substantially to arrange for medically necessary services that the MCO is required to provide under law or under its Agreement.
2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid and CHIP Programs.
3. Acts to discriminate among Members based on their health status or need for health care services.
4. Misrepresents or falsifies information that it furnishes to CMS, DHS, Members, potential Members, or Health Care Providers.
5. Fails to comply with requirements for Physician Incentive Plans as set forth in 42 CFR §§422.208 and 422.210.
6. Fails to comply with the Agreement requirements pertaining to Program Integrity and Fraud, Waste and Abuse.
7. 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.

8. Fails to comply with MCO contract requirements and any applicable federal and state law, regulation, or guidance.

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:

1. Imposing civil monetary penalties of a minimum of $1,000.00 per calendar day per violation for noncompliance.
2. Withholding all or part of the Capitation Payments or State-Funded Residential Habilitation Subsidies.
3. Fines or penalties consistent with those applied to nursing facilities or ICFs for individuals with Intellectual Disabilities in the Commonwealth.
4. Requiring the submission of a CAP.
5. Suspending or limiting enrollment of new recipients.
6. 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 §§ 1001 and 1002; 62 P.S. § 1407 and 55 Pa. Code §§ 1101.75 and 1101.77.
7. Temporary management subject to applicable Federal or State law.
8. Termination of the Agreement.

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

These sanctions may be progressive. DHS maintains an effective, reasonable, and consistent sanctioning process as deemed necessary to protect the integrity of the Medicaid and CHIP programs.

Within the past three years, DHS has taken actions to enforce MCO compliance with state and federal rules including:

- Issued sanctions of $816,999 in 2022, $281,000 in 2021 and $32,000 in 2020 for reasons including claims processing timeliness and encounter data errors.
- Implemented five work plans including notice, hearing, and third-party liability-related issues.
- CAPs developed for the following: failure to provide reports, audits, or files that were specified by the Agreement by the applicable due date for provider network issues, service denials, notice requirements, encounter data, and pharmacy rates.
- Levied a MCO assessment penalty as authorized under Act 92 of the 2015 (62 P. S. §§ 801-I – 812-I).

External Quality Review

DHS contracts with the Island Peer Review Organization (IPRO) as the EQRO that serves all managed care programs. The EQRO performs the mandated standard 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)–(iii) (in other words, DHS does not leverage the non-duplication option for its EQRO).

The EQR Technical Reports include MCO and program specific reports as well as a statewide Medicaid report. The following link provides that statewide Pennsylvania Medicaid report: https://www.pa.gov/en/agencies/dhs/resources/medicaid/managed-care-quality-strategy.html.

Additionally, IPRO subcontracts with Aqurate Health Data Management which is licensed by NCQA 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, the EQRO is used to validate compliance status with performance measures and the PIP and to annually determine compliance with the contractual agreement and all managed care regulations.

Summary of EQR Report Findings and Recommendations

In its 2021 review, IPRO noted strengths of PH and CHIP-MCO compliance with state and federal regulation standards and HEDIS compliance audits, and validation of PAPMs. BH-MCOs submitted new PIP proposals, calculated, and validated follow-up after hospitalization performance measures and readmission within 30 days of inpatient psychiatric discharge. BH-MCOs were in compliance with assurance of adequate capacity and services, confidentiality, Health Information System, and subcontracts. The CHC-MCOs were compliant with reviewed federal regulations, had compliance determinations for their PIPs and completed HEDIS audits and validated Adult Medicaid CAHPS survey sampling frames. However, IPRO identified a number of opportunities for improvement:

- None of the BH-MCOs met the:
  - Quality Compass 75th percentile for All-Ages/Overall (6+) HEDIS 7-day Follow-up After Hospitalization for Mental Illness Measure.
  - Quality Compass 75th percentile for All-Ages/Overall (6+) HEDIS 30-day Follow-up After Hospitalization for Mental Illness Measure.
  - OMHSAS goal of 10% or less for readmission within 30 days of inpatient psychiatric discharge.
- All BH-MCOs were only partially compliant with five of the nine categories of standards, including Enrollee Rights and Protections, and were partially compliant with Grievance System.
- CHC-MCOs had challenges with producing valid performance measurement (either in producing valid rates, producing biased rates, or with producing timely submittals).
- PH-MCOs experienced performance issues for P4P measures and recommended a root cause analysis and action plan to identify contributors to poor performance. The measures with poor performance varied by MCO but all MCOs had at least one identified measure requiring a root cause analysis and action plan.

IPRO delineated specific recommendations for individual MCOs in their EQR Technical Reports regarding their PIPs, Performance Measures, CAHPS Survey, and regulatory compliance. These recommendations can be found beginning on page 75 of the 2021 Pennsylvania Statewide Managed Care Annual Report (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/hc-quality-measures-reports/2021-quality-measures/2021-pa-statewide-bba-report.pdf).

For ACAP, IPRO recommended looking for opportunities to streamline recordkeeping and systems that would help address deficiencies (particularly in the area of documenting member records related to service planning and provision) despite ongoing staffing shortages.

In response to these findings and recommendations, offices undertook the following actions:

- OMAP reviewed IPRO's Quality Strategy assessment and used the IPRO recommendations as it was revising and updating this Quality Strategy. For example, OMAP added numeric targets/goals for quality outcomes in performance measures and network adequacy monitoring program language to ensure quality goals aligned with all relevant network adequacy requirements.
- OLTL and IPRO worked with the CHC-MCOs to provide detailed technical specifications and technical assistance to ensure the MCOs are accurately reporting measures. A new HEDIS LTSS measure was reported as biased resulting in OLTL and IPRO proactively including the LTSS measures in the annual HEDIS audit. This level of responsiveness is not required by NCQA but was deemed necessary by DHS to ensure timely and accurate reporting. It was found that one MCOs was not capturing data correctly due to systems issues and was incorrectly reporting rates a zero. The MCO did perform a fix to the system for ongoing correct reporting. IPRO conducted an in-depth enrollment study with each of the MCOs to ensure the MCOs could properly identify the correct populations to include in each measure.
- CHIP-MCOs are required to address and resolve the findings by the next EQRO report. If needed, CHIP program staff, IPRO and the CHIP-MCO will meet to discuss the findings and a CAP would be implemented if necessary.
- OMHSAS has implemented a P4P program to encourage Primary Contractors and associated BH-MCOs to improve rates of 7-day and 30-day Follow-up After Hospitalization for Mental Illness and Readmission withing 30 days of inpatient psychiatric discharge. The P4P will also address follow-up hospitalization for African-Americans starting in 2024.

Review and Evaluation of the Quality Strategy

DHS has historically used its internal managed care monitoring processes, plus the results of EQRO assessment and feedback from CMS to evaluate the results of its Quality Strategy. For example, the monitoring tools outlined in this report including network and access standards, contractual deliverables, complaints, grievances and appeals all provide insight into MCO quality performance. The EQR Reports outline MCO performance, by program, on performance measures, PIPs, and other interventions. These are reported not only in a statewide Annual Technical Report but also through MCO specific reports.

These indicators help DHS assess the effectiveness of the existing quality strategy as well as inform the development of updates to the strategy. Specifically, the EQR Report https://www.pa.gov/en/agencies/dhs/resources/medicaid/managed-care-quality-strategy.html provides detailed information on performance measure progress.

The most recent report, however, is for a period impacted by the COVID-19 pandemic. Like states across the country, Pennsylvania experienced changes in how members accessed care, the types of care accessed, and provider capacity to deliver care both as a result of pandemic-related service demands and mitigation strategies (e.g., limits on in-person interaction), as well as ongoing changes to workforce, supply, and care delivery. These changes make interpreting changes in performance measures difficult. For example, many people avoided well-visits and inpatient drug and alcohol treatment during the heights of the pandemic.

Similarly, inpatient and ED utilization changed as members accessed more care for COVID-19-related conditions but less care for other needs. In addition, state, MCO and provider priorities shifted to address the emergent needs of the pandemic. Performance measure results must be read and interpreted in that context, making a direct tie of results to the objectives in the strategy difficult.

DHS understands the CMS Medicaid and CHIP Quality Strategy Toolkit provides a more detailed framework for this evaluation including specific tracking of measures associated with the goals and objectives of the strategy and a progress analysis tied to those measures. The structure of the previous Quality Strategy did not explicitly tie goals, objectives, and measures in a way to meet those requirements but this Quality Strategy update does provide a framework that will allow for a more comprehensive evaluation consistent with the Toolkit.

DHS will update its EQRO contractual requirements to ensure the EQR review includes the evaluation requirements of the Toolkit, including:

- An assessment of whether DHS made progress on its quality strategy goals and objectives (including providing baseline data for each metric and calculating annual progress and improvement over time) and whether it is continuing with or revising goals as a result.
- An analysis of areas in which DHS did not meet or make progress, an explanation of likely factors and how DHS is modifying the MCQS to consider those reasons.
- Whether managed care quality provisions are aligned and focused on consistent aims and goals, and whether they address performance on Child and Adult Core Set measures (e.g., areas of low performance).
- Whether and how the state acted on EQR recommendations.

Conclusion

Grounded in the focused domains of increasing value, supporting health equity, and addressing SDOH, this MCQS takes a broad view of opportunities to improve member health. At the same time, it acknowledges that the Commonwealth, MCOs, providers and members are all emerging from the pandemic with new approaches and opportunities, as well as ongoing challenges, including workforce and supply chain issues.

As the delivery system landscape continues to respond and evolve, this MCQS provides a roadmap for DHS to support improved quality for all MA and CHIP members. As detailed throughout the MCQS, DHS strives to improve the health of its members across each of its managed care programs through the implementation of strategic initiatives that support its three main goals:

1. Increase access to healthcare services.
2. Improve the health outcomes of populations.
3. Promote efficient and effective use of taxpayer resources.

These strategic initiatives, paired with comprehensive program monitoring, contractual standards, evaluation of performance measures, and other tools, support DHS in achieving its goals and objectives. By aligning these objectives with broader strategies such as directed payments, disparity initiatives, EQR activities and others, DHS is establishing a consistent and comprehensive approach to quality improvement.