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Pennsylvania Adult Community Autism Program External Quality Review Annual Technical Report

2025–2026 Reporting Cycle

April 2026

pennsylvania DEPARTMENT OF HUMAN SERVICES

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Per *Title 42 CFR § 438.364(a)(7)*, no managed care plan was exempt from the external quality review activities conducted in 2025.

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I. Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care plans (MCPs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCPs. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCPs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCP. **Box 1** lists the definitions per *Title 42 CFR § 438.320 External quality review*.[1]

Box 1: *Title 42 CFR § 438.320* Definitions

- **Access**, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under network adequacy standards and availability of services
- **External quality** review means the analysis and evaluation by an EQRO, of aggregated information on quality of, timeliness of, and access to the health care services that an MCO, PIHP, PAHP, or PCCM entity, or their contractors furnish to Medicaid beneficiaries.
- **External quality review organization** means an organization that meets the competence and independence requirements and performs external quality review and other EQR-related activities.
- **Quality**, as it pertains to external quality review, means the degree to which an MCP increases the likelihood of desired outcomes of its enrollees through (1) Its structural and operational characteristics; (2) the provision of services that are consistent with current professional, evidenced-based-knowledge; and (3) Interventions for performance improvement.

CFR: Code of Federal Regulations; §: section; EQRO: external quality review organization; MCP: managed care plan; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan; PCCM: primary care case management; EQR: external quality review.

Title 42 CFR § 438.364 External review results (a) through *(d)* requires that the annual EQR be summarized in a detailed annual technical report (ATR) that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that MCPs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCPs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

To comply with *Title 42 CFR § 438.364 External review results (a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Developmental Programs (ODP) contracted with IPRO, an EQRO, to conduct the EQR activities for PA Adult Community Autism Program (ACAP) for state fiscal year (SFY) 2025. The EQR scope in SFY 2025 covered one voluntary prepaid inpatient health plan (PIHP), Keystone Autism Services (KAS), that was contracted to furnish covered services for up to 200 persons from the state's Medicaid adult autism population.

Scope of EQR Activities Conducted

This EQR ATR focuses on the four mandatory activities that were conducted for SFY 2025. These activities, as defined by the Centers for Medicare and Medicaid Services (CMS), are the following:

- ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs)** – This activity validates that MCP PIPs were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Mandatory Protocol 2:* Validation of Performance Measures** – This activity assesses the accuracy of performance measures reported by each MCP and determines the extent to which the rates calculated by the MCP follow state specifications and reporting requirements.
- ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations** – This activity determines MCP compliance with its contract and with state and federal regulations.
- ***CMS Mandatory Protocol 4:* Validation of Network Adequacy** – This activity assesses MCP adherence to state standards for distance for specific provider types, as well as the MCP's ability to provide an adequate provider network to its Medicaid population.

[1] 42 CFR § 438.320

CMS defines "validation" in Title 42 CFR § 438.320 Definitions as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

Title 42 CFR § 438.364 External quality review results(a)(6) requires each ATR include "an assessment of the degree to which each MCP, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." This section summarizes findings from SFY 2025 and assesses the degree to which the PIHP has addressed the opportunities for improvement made by IPRO in the 2025 EQR ATR.

Findings

The results of these EQR activities are presented in individual activity sections of this report. Each of the activity sections includes information on:

- data collection and analysis methodologies;
- comparative findings; and
- where applicable, the MCP's performance strengths and opportunities for improvement.

Conclusions and recommendations for improvement are provided for each activity, summarized in each section of this report.

The *CMS External Quality Review (EQR) Protocols* published in February 2023 state that an Information Systems Capabilities Assessment (ISCA) is a required component of the mandatory EQR activities. An ISCA was completed for KAS in 2024. Findings from that ISCA have been used to validate SFY 2025 findings as applicable to the EQR areas.

Validation of Performance Improvement Projects

In 2025, ACAP completed year 1 of the PIP "Addressing Anxiety and Depression PIP." IPRO reviewed and validated the findings of the year-1 report.

Validation of Performance Measures

KAS met its SFY 2025 QAPI performance measure (PM) targets for the following measures: Law Enforcement Incidents, Behavioral Health Crisis Events, Psychiatric Hospitalization Follow-up, (Timeliness of) Initial PCP Visits, Physical Access, Cultural Competency, Feeling Valued and Heard, Person-Centered Approach, Goal Attainment Scale, and Residential Rehabilitation. KAS did not meet its QAPI targets for the following measures: Annual Dental Exam, Medication Therapeutic Management Plan, and Competitive Integrated Employment.

Review of Compliance with Medicaid Managed Care Regulations

For SFY 2025, KAS continued to develop policies and procedures in a number of areas that previously lacked such policies and procedures. Under "Standards, Including Enrollee Rights and Protections," KAS was found partially compliant with six of the eleven standards reviewed, and it was found not compliant with Practice Guidelines. KAS was partially compliant with "Quality Assessment and Performance Improvement" (QAPI) standards and met all requirements for "Grievance Systems" standards.

Validation of Network Adequacy

KAS was found to be partially compliant with travel time standards for physician, dental, vision, and psychiatric services in SFY 2025. Still, KAS was near (99.5%) compliance levels for all four categories and was found fully compliant with travel time standards for all remaining provider types.

Conclusion and Recommendations

Validation of PIPs

After revision to address issues identified in the first review, KAS's "Addressing Anxiety And Depression" PIP proposal was approved on September 30, 2024, and PIP implementation began on October 1, 2024. KAS submitted its year-1 report in September 2025. KAS received moderate confidence rating for methodology and a moderate confidence rating that the PIP produced evidence of improvement as measured by its performance indicators.

Validation of Performance Measures

KAS should review findings from the compliance review particularly as relates to QAPI as well as conduct targeted root cause analyses of the observed underperformance. This may entail case reviews with support teams to better understand the specific barriers that arose which might then inform more general improvements in documentation, monitoring, and follow-up.

In response to the previous recommendation that ACAP add more measurable goals to QAPI, the program significantly expanded the number and types of measures being reported by the MCP, increasing to 18 metrics from nine last year. The PM set now includes quantifiable process and outcome measures of care access, timeliness, and quality at both the member and provider levels. ODP also spent SFY 2025 planning for the eventual addition of long-term services and supports (LTSS) measures, including home- and community-based services (HCBS) measures, to its QAPI framework. Furthermore, ODP continues to set goals for their QAPI PMs to bring ACAP into closer alignment with the DHS quality strategy.

Review of Compliance with MMC Regulations

Assurances of Adequate Capacities and Supports
KAS was compliant with all elements of this standard.

Availability of Services
KAS was partially compliant with this standard. IPRO recommends that KAS ensure that all applicable federal and state language requirements are reflected consistently across its policies and procedures, including for appointment wait times in specific scenarios. KAS should review its policies and procedures annually, making revisions as necessary to ensure alignment with both federal regulations and state contract requirements. Accordingly, when entering into a new state contract, KAS is advised to conduct a comprehensive review and update of all policies to ensure ongoing compliance.

Confidentiality
KAS was compliant with this standard.

Coordination and Continuity of Care
KAS was partially compliant with this standard. Some of the case files reviewed did not meet ISP standards related to timeliness of relevant assessments and documentation. ODP's recommendations related to these areas were not fully addressed and remain opportunities for improvement. KAS was also found partially compliant with certain policies and procedures requirements pertaining to coordination and continuity of care. KAS should coordinate the authorized services provided to participants between settings of care with services the participants receive outside of KAS. KAS should also develop a policy to specify that the SCs assist participants with obtaining and coordinating needed covered and other services, as well as housing, medical, social, vocational, and other community services, regardless of funding source, and the service should include both the development of an ISP and ongoing supports coordination. KAS should develop a workflow to ensure that all members receive the development of an ISP and ongoing supports coordination. In addition, KAS should develop a policy and procedure to inform all providers and ODP, as necessary, of the participant's needs as identified by the contractor and the authorized services delivered to the participant to prevent duplication of activities.

Coverage and Authorization of Services
KAS was partially compliant with this standard. Three out of 19 participants in the ISP sample did not have all the assessments completed within the defined timeframes. IPRO's prior recommendation, that KAS implement a tracking mechanism for all elements of authorization cases including timeliness, information on phone calls, and all correspondence, remains.

Disenrollment Requirements and Limitations
KAS was exempt from review for this standard since ODP is responsible for disenrolling members from ACAP.

Emergency and Post-stabilization Services
KAS was compliant with this standard.

Enrollee Rights and Protections
KAS was partially compliant with two review elements and non-compliant with a third. KAS should add a feature to their electronic provider directory which enables users to search for individual practitioners in addition to general providers or practices. KAS should also enhance the electronic directory by adding information about the availability of telehealth services. KAS should develop a policy to ensure all staff and network providers who have contact with potential applicants are fully informed and understand its policies for outreach, enrollment, and disenrollment. Finally, the EQRO recommends that KAS update policies and program objectives that reflect federal regulations and state contract requirements to address KAS's quality and performance indicators, including participant satisfaction.

Health Information Systems
KAS was partially compliant with two review elements and non-compliant with a third. KAS should add ZIP code information to provider location in its quarterly medical services reports. Furthermore, KAS should add telehealth availability as an element to their publicly available provider directory tool. Finally, KAS should implement a standards-based patient application programming interface (API) that allows participants to

access their claims and encounter information through third-party applications of their choice. KAS should work with ODP to identify potential funding which might support meeting this federal requirement.

Practice Guidelines

KAS was not compliant for all review elements. The EQRO recommends that KAS further develop its Practice Guidelines Policy to reflect the process and mechanisms involved in the application, utilization, review, and education of its guidelines and to encourage provider participation. KAS should consider posting practice guidelines on its website for provider access. Guidelines should be made available, upon request, to participants and applicants. KAS should develop additional written policies and procedures that address assurances of timely resolution of authorization requests, decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply and are consistent with the guidelines as stated in the federal regulations and state contract requirements.

Provider Selection

KAS was partially compliant with this standard. KAS met all provider credentialing and provider recredentialing requirements in the case files that were sampled and reviewed. However, KAS should develop and update, as needed, policies and procedures for communications, executions and terminations of provider contracts, and notifications within timeframes as stipulated by applicable federal and state standards.

Subcontractual Relationships and Delegation

KAS was compliant with this standard.

Quality Assessment and Performance Improvement

KAS was partially compliant with 5 review elements and non-compliant with 1 review element of this standard, with deficiencies centering on the robustness of KAS's QAPI plan and process. IPRO recommends that KAS develop a strategic plan to achieve its QAPI goals. The plan should have a 1-year timeline at a minimum and ideally a longer-term horizon as well (e.g., 5-year plan). The goals and plan should cover all relevant quality indicators in the QAPI PM set, as well as other relevant QAPI key performance indicators (KPIs) that KAS develops to track progress on the QAPI PMs.

The plan should describe how QAPI will be implemented, monitored, and evaluated to include participant and provider perspectives and inputs. The plan should also address proper governance processes, describing how goals and priorities will be developed, how improvement and remediation activities will be monitored, and mechanisms for reporting and follow-up. Processes should conform to existing ancillary requirements, including timely review of progress of corrective action plans (CAPs) through the Member Advisory Committee (MAC) and the board of directors. Formalization of the plan should be documented in appropriate records, including any minutes, and version history tracked on the plan document itself.

IPRO recommends that KAS expand utilization monitoring and reporting to all ACAP-covered services, including medical and behavioral health (BH) services provided in the larger network, and reporting should cover all (both under- and over-) utilization. As long as authorizations occur in Home and Community Services Information System (HCSIS), this may require working with ODP and its Bureau of Supports for Autism and Special Populations (BSASP) on a crosswalk to join in-house and PA HCSIS authorization and utilization data on unique member identifications (IDs) and possibly dates of service.

IPRO recommends that KAS document in its relevant policies, in concrete terms, the mechanism to assess the quality and appropriateness of care furnished to all participants, including those with special health care needs and those who need LTSS. This mechanism, if relevant, should be described in the larger QAPI strategic plan.

IPRO recommends that KAS continue working with ODP to develop, wherever feasible, population-level quality benchmarks for its QAPI PMs to enhance the monitoring and evaluation of the ACAP program as a whole. Improvement plans should be developed and documented in the annual (QAPI) report for areas of underperformance. The annual report should be reviewed with the MAC, and this review should be documented in the MAC meeting minutes.

Validation of Network Adequacy

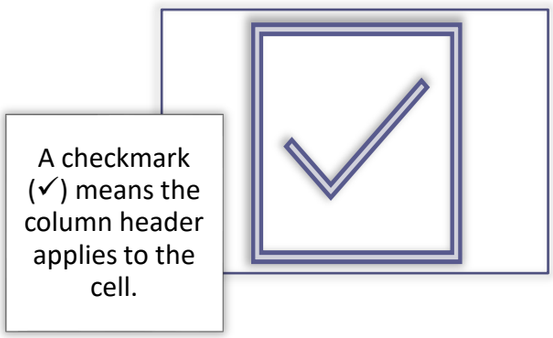
KAS should continue to monitor geographic areas in its network where access to certain provider types is most susceptible to non-compliance based on current and projected distributions of its enrollment in order to inform its strategic planning.

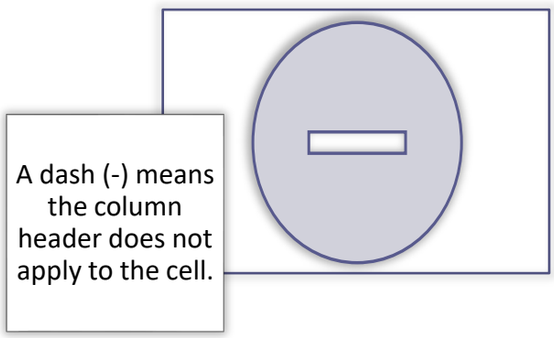
ODP should continue to look for ways to positively measure compliance with all its indicators. Maximum travel time indicators that are currently measured by documented grievances or self-report survey responses should instead be incorporated into geo-access reporting similar to the monitoring currently conducted for physicians, optometrists, dentists, and psychiatrists. In addition, it is recommended that ODP add post-stabilization services to its monitoring for compliance with travel time standards. This will be key to ODP

meeting its goal to monitor network adequacy across all four of the major types of ACAP services: routine, urgent, emergency, and post-stabilization. In 2025, ODP was actively engaged in addressing these items and further developing its network adequacy monitoring program to not only align with federal requirements but also state quality strategy objectives for Medicaid managed care (MMC).

Note on Accessibility

Several tables in this report use a checkmark to indicate that the column header applies to the cell. When the column header does not apply, the cell has been grayed out. A dash has been added to grayed out cells so that readers using assistive technology understand that the column header does not apply.





II. PA Adult Community Autism Program

The ACAP is a fully integrated program that provides physical health (PH), BH, and LTSS, including HCBS, services to adults with an autism spectrum disorder (ASD) living in Chester, Cumberland, Dauphin, and Lancaster Counties. ACAP is a voluntary PIHP program approved under the authority of 1915(a) of the Social Security Act (SSA) and is overseen by ODP. The program is administered under the "Agreement for the Adult Community Autism Program" (referred to as the "agreement") with KAS. Additional ACAP services not covered by the PIHP agreement are administered through fee-for-service (FFS) and include: inpatient facility, ambulatory surgical center, home health care, family planning, transportation, renal dialysis center, laboratory, X-ray clinic, and pharmacy. As of December 2024, 181 members were enrolled in the program.

Assessment of Pennsylvania Quality Strategy Review

Managed Care Quality Strategy, 2023

PA's current quality strategy, dated December 2023, was developed with input from stakeholders. The quality strategy includes objectives, standards, and goals for the following overarching areas that impact health care services: network adequacy and availability; continuous quality improvement (CQI); quality metrics and performance targets; PIPs; external independent reviews; transitions of care; health disparities; intermediate sanctions; LTSS; and non-duplication of EQR activities.

The quality strategy elucidates a high-level mission, "...to assist Pennsylvanians in achieving safe, healthy, and productive lives while being an accountable steward of Commonwealth resources."[2] It provides a set of guiding principles that drive a managed care program that is person-centered, relationship-driven, community-based, data-driven, collaborative, innovative and equitable.

Goals and Objectives

PA's goals for ACAP align with the mission, vision, and values of DHS. Each MMC program has unique, specific goals and objectives, but they all relate back to DHS's overarching priorities. These priorities are listed in **Table 1**.

Table 1: Pennsylvania's Managed Care Quality Strategy Goals, 2023

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

In addition to these goals, DHS has articulated the following focus domains that drive their strategy:

- increasing value,
- supporting health equity,
- addressing social determinants of health (SDoH).

These statewide goals align well with the CMS National Quality Strategy Goals, shown in **Figure 1**.

Figure 1: CMS National Quality Strategy Goals CMS: Centers for Medicare and Medicaid Services. Source: CMS National Quality Strategy | CMS.

[2] https://www.pa.gov/agencies/dhs/resources/medicaid/managed-care-quality-strategy

The state's objectives track progress toward achieving established goals, as well as identify opportunities for improvement. There are subobjectives across the five programs within each of these three overarching goals. The ACAP program is administered by ODP, whose goals are described in **Table 2**.

Table 2: ODP Goals

Objective	Measure/Target	Related EQR Protocols
Goal: Increase Member Access to Healthcare Services – 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. • By 2024, 90% of members will have had a dental exam. • By 2024, 50% of members will decrease or maintain (if at 8) their social isolation score (social isolation scores range from 8 to 40).	Protocol 1. Validation of Performance Improvement Projects.

ODP: Office of Developmental Programs; EQR: external quality review.

Methodology of EQR Review of the Managed Care Quality Strategy

IPRO reviewed the PA Medical Assistance (MA) and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy (MCQS) using the rubric from the *CMS Medicaid and CHIP Managed Care: Quality Strategy Toolkit Summary, June 2021*.

CMS's vision of the EQR role in evaluating the quality strategy is captured in **Figure 2**.

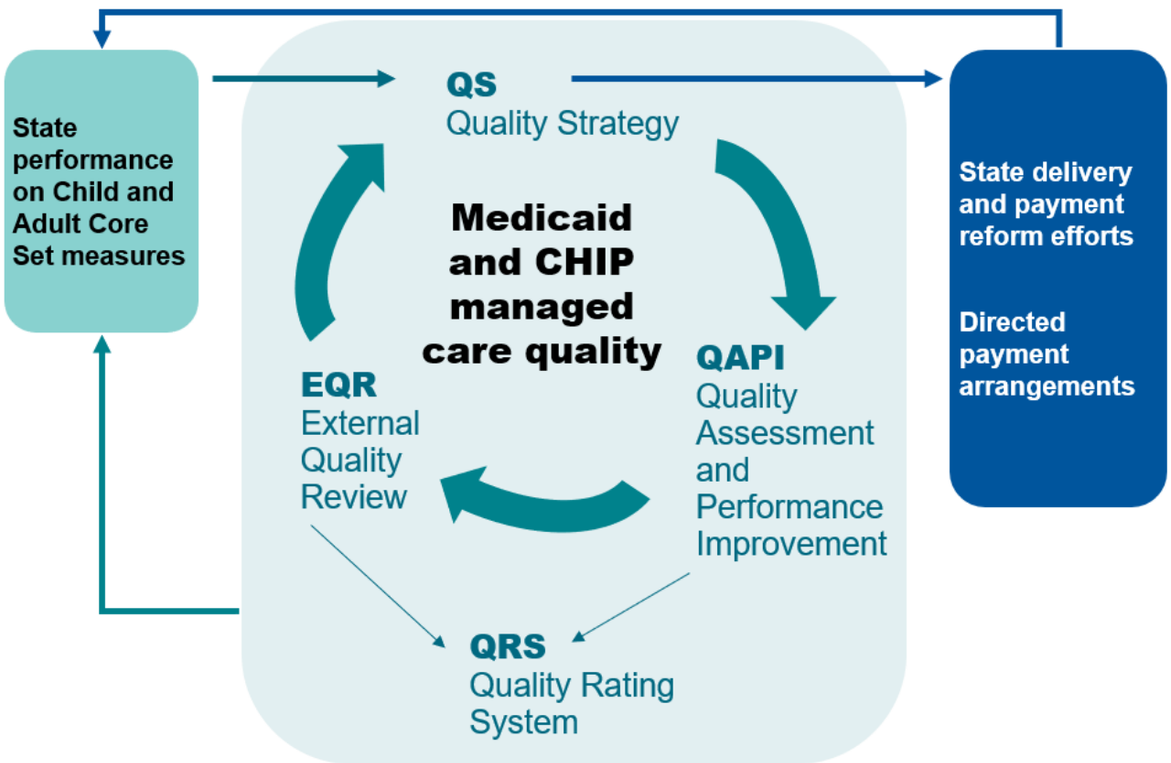


Figure 2: Relationship Between State Medicaid and CHIP Managed Care Quality Initiatives Source: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit.

Observations

The structure of ACAP is addressed in detail, including the regional approach, and the number and types of plans.

DHS describes its process for seeking input from stakeholders in developing its quality strategy. Stakeholders who were identified include: Medicaid members, the public, the Medicaid Assistance Advisory Committee, the County Administrators Advisory Committee, the PA Mental Health Planning Council, and MCPs.

There are specific goals set, with baseline rates and statewide performance targets. Where available, goals are based on standard PMs. There is ample room within the goal structure to make ongoing adjustments to measures and targets based on the evolving experience of monitoring goal progress and changes in the population health experience of the members.

Monitoring

DHS outlines the details of their MCP monitoring activities within the MCQS. These include:

- standard annual review of Healthcare Effectiveness Data and Information Set (HEDIS®) measures, including:
  - comparison of results to goals,
  - root cause analysis on missed targets, and
  - collaborative remediation planning, goal setting, and re-evaluation with MCPs that miss targets;
- ongoing review of MCP compliance with state and federal regulations; and
- the Medicaid Enterprise Monitoring Module (MEMM) dashboard, used for cross program aggregation of quality indicator monitoring. Among the core quality domains that are routinely monitored via MEMM are: Network Adequacy, Compliance, PMs, Surveys, Care Management, and others.

IPRO notes that while the majority of goals have timelines that begin with MY 2024 or later, there are a number of goals that were set for MY 2023. As of this report, DHS has not posted any progress reporting on its quality goals.

Discussion of the Quality Management Program

The 2023 MCQS contains detailed descriptions of the statewide PA initiatives underway or under consideration for achieving the stated goals.

SDoH/Health equity are targeted with increased detail in the new strategy document. DHS documents its engagement with stakeholders in developing their statewide SDoH strategy and provides details on activities completed and those being initiated.

There is a section on PIPs with topics. There are high-level descriptions of project aims and key interventions for each PIP. For ACAP, the PIP topic in 2023 was “Reducing Social Isolation.” The report directs the reader to the EQR ATR on the DHS website for detailed results and analysis.

There is a section on network adequacy standards that includes details on time, distance, and appointment availability broken down by provider type and geographic region. This section also describes DHS’s activities in monitoring compliance with these standards.

There is a description of the process DHS uses to review each MCP’s clinical practice guidelines, including the participation of medical experts and the basis in scientific and reliable clinical evidence.

The MCQS delineates the provision that could trigger MCP sanctions and the possible sanctions or penalties that could be levied. The report contains a listing of MCP sanctions imposed within the past 3 years.

There is a mention of five work plans that were implemented and the high-level topics, as well as high-level mention of CAPs that were developed. It is not entirely clear from the narrative where the status of those work plans and CAPs currently stands and, if ongoing, what the specific metrics for completion and ongoing monitoring of those projects entail.

Recommendations

The 2023 MCQS addresses several of the recommendations made in the 2023 ATR:

- Strong numeric targets were established for PMs.
- A more robust discussion of PIPs has been added.
- A detailed discussion of quality interventions where areas of underperformance were identified has been added.

DHS should consider creating an annual progress report detailing progress on the ACAP goals, any obstacles encountered, and plans to address obstacles and capture success strategies where significant progress and/or achievement of goals has been observed

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) Performance improvement projects establishes that the state must require contracted MCPs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCP. Further, MCPs are required to design PIPs to achieve significant, sustained improvement in health outcomes. **Box 2** details the required PIP elements.

Box 2: *Title 42 CFR § 438.330* PIP Required Elements

1. Measurement of performance using objective quality indicators
2. Implementation of interventions to achieve improvement in access to and quality of care
3. Evaluation of the effectiveness of interventions based on the performance measures
4. Planning and initiation of activities for increasing or sustaining improvement

CFR: Code of Federal Regulations; §: section; PIP: performance improvement project.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, PA contracted with IPRO to validate the PIPs that were underway in 2024.

Technical Methods of Data Collection and Analysis

IPRO's validation process begins at the PIP proposal phase and continues through the life of the PIP. During the conduct of the PIPs, IPRO provides technical assistance to each MCP. Technical assistance includes feedback.

CMS's *Protocol 1. Validation of Performance Improvement Projects* was used as the framework to validate each PIP. **Figure 3** details the mandatory EQR Protocol 1 activities.

Activity 1: Assess the PIP Methodology

- Step 1: Review the selected PIP topic.
- Step 2: Review the PIP aim statement.
- Step 3: Review the identified PIP population.
- Step 4: Review the sampling method.
- Step 5: Review the selected PIP variables and performance measures.
- Step 6: Review the data collection procedures.
- Step 7: Review data analysis and interpretation of PIP results.
- Step 8: Assess the improvement strategies.
- Step 9: Assess the likelihood that significant and sustained improvement occurred.

Activity 2: Perform Overall Validation and Reporting of PIP Results

- Step 1: Assign validation ratings.
- Step 2: Report findings and performance measure data.

Figure 3: EQR Protocol 1 Activities PIP: performance improvement project; EQR: external quality review.

In accordance with the EQR PIP validation protocol issued by CMS in February 2023, IPRO replaced the former scoring with two qualitative assessments of the PIP, expressed in terms of levels of confidence (High, Moderate, and Low or None):

1. EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases; and
2. EQRO's overall confidence that the PIP produced evidence of significant improvement.

The results for sustainable improvement will be reported by the MCP and evaluated by the EQRO at the end of the current PIP cycle and reported in next year's EQR ATR. **Figure 4** displays the validation determinations and corresponding confidence levels.

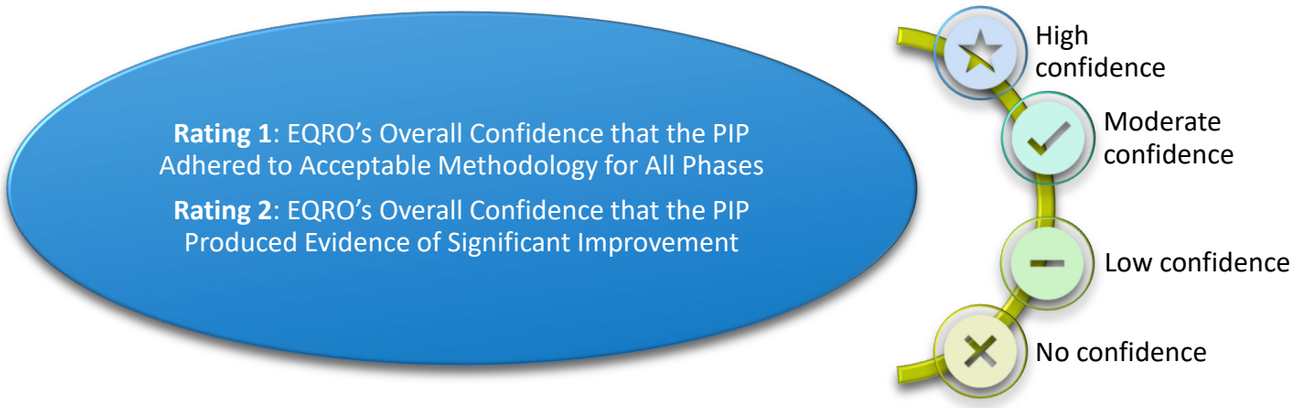


Figure 4: EQR Overall Validation Ratings EQRO: external quality review organization; PIP: performance improvement project.

Description of Data Obtained

In SFY 2024, ACAP completed the "Reducing Social Isolation" PIP and launched another, "Addressing Anxiety and Depression PIP." The final report of the "Reducing Social Isolation" PIP was received in late 2023, and the results of that review were presented in last year's ATR.

Addressing Anxiety and Depression PIP

In 2024, ACAP launched its "Addressing Anxiety and Depression PIP." Addressing anxiety and depression in individuals with ASD has emerged as a critical objective, highlighted by both the World Health Organization (WHO) and the autism community.[3] Data suggest there are opportunities for improving mental health (MH) outcomes and overall quality of life for PA ACAP members who are experiencing symptoms of anxiety or depression that could be addressed through PIP interventions. The lifetime prevalence of anxiety and/or depression among the ASD population is 42% and 37%, respectively.[4] These rates are considerably higher than rates for the general population, which are approximately 7% for depression and between 1% and 12% for anxiety, depending on the specific anxiety diagnosis. Anxiety and depression are the most common comorbid MH diagnoses for ACAP participants. As of the end of third quarter (Q3) 2023, 38% (72 out of 188) of ACAP members were diagnosed with anxiety and/or depression. By promoting early screening, diagnosis, and treatment of anxiety and depression, this PIP topic seeks to improve outcomes, including reduction of symptom burden, for ACAP members suffering from anxiety and/or depression.

KAS will use the following performance indicators for this PIP to measure improvement in anxiety/depressive symptoms:

1. Indicator 1: Percentage of members who completed the ACAP assessment tool who reported anxiety less frequently than "often (about once a day)" when averaged over the anxiety subdomain Likert items of the assessment.
   - Numerator: number of members who completed the ACAP assessment and reported anxiety less frequently than "often (about once a day)" when averaged over the anxiety subdomain Likert items of the ACAP (a simple average score < 3).
   - Denominator: number of members who completed the ACAP assessment.
2. Indicator 2: Percentage of participants who report less frequent feelings related to anxiety compared to their baseline anxiety subdomain average.
   - Numerator: number of members who completed the ACAP assessment and reported less frequent feelings related to anxiety compared to their baseline anxiety subdomain average.
   - Denominator: number of members who completed the ACAP assessment.
3. Indicator 3: Percentage of members who completed the ACAP assessment tool who reported depression less frequently than "often (about once a day)" when averaged over the depression subdomain Likert items of the assessment.
   - Numerator: number of members who completed the ACAP assessment and reported depressive feelings less frequently than "often (about once a day)" when averaged over the depression subdomain Likert items of the ACAP assessment (a simple average score < 3).
   - Denominator: number of members who completed the ACAP assessment.

[3] El, Baou, C., Sauders, R., Buckam J., Mandy, W., Dagnan, D., O'Nions, E., Pender, R., Clements, h., Pilling, S., Richards, M., John, A., and Stott, J. (2023). Effectiveness of primary care psychological therapy services for treating depression and anxiety in autistics adults in England: A retrospective, matched, observational cohort study of national health-care records. *Lancet Psychiatry, 10.* 944–954.

[4] Hollocks, M. J., Lerh, J. W., Magiati, I., Meiser-Stedman, R., & Brugha, T. S. (2018). Anxiety and depression in adults with autism spectrum disorder: a systematic review and meta-analysis. *Psychological medicine*, *49*(4), 559–572.

4. Indicator 4: Percentage of participants who report less frequent feelings related to depression compared to their baseline depression subdomain average.
    - Numerator: number of members who completed the ACAP assessment and reported less frequent feelings related to depression compared to their baseline depression subdomain average.
    - Denominator: number of members who completed the ACAP assessment.

To calculate a simple subdomain average for each member assessed, a simple average of the Likert scale items is calculated across the subdomain (e.g., anxiety) for that individual.

These four indicators will be measured quarterly through administration of the ACAP assessment tool, specifically, the Likert-scaled questionnaire items in the MH domain comprising the anxiety and depression subdomains. For each condition, all items of that subdomain will be used to calculate an unweighted average score for the condition.

KAS used Q2 and Q3 calendar year (CY) 2024 (April−September 2024) data entered into the QuestionPro® system for the baseline MY and included the data as the baseline results in the proposal report. Members enrolling on or after 10/1/2024 establish their baselines upon enrollment.

KAS will be expected to carry out certain activities during this PIP:
1. Conduct a needs (and strengths/assets) assessment of the ACAP population, provider network, and support system related to identification, treatment, and management of anxiety and depression conditions among its members. Assessment must be grounded in research, data, and analysis.
2. From this three-pronged assessment, set specific, measurable, achievable, relevant, and timebound (SMART) goals for improving on the PIP performance indicators from baseline through to year 3.
3. Identify concrete objectives related to member-, provider-, and system-level improvements to achieve these goals. The objectives will, therefore, essentially comprise the strategic approach for the PIP.
4. Identify barriers that prevent members from taking the ACAP assessment and reporting symptoms of anxiety and depression. Identify barriers that prevent members with anxiety and/or depression from receiving needed treatment that is timely and therapeutically aligned. Identify barriers that prevent these members from staying engaged in anxiety and/or depression treatment and achieving ISP goals, including symptom alleviation and improvement in overall quality of life and satisfaction.
    - Conduct barrier analysis in which KAS identifies member-, provider-, and system-level barriers (encountered by KAS's members, providers, and staff) to achieve its desired performance as ultimately measured by its performance indicators.
5. Design and develop interventions that address the barriers and track progress (on intervention activities and ultimately on removing barriers) using intervention tracking measures (ITMs).
    - At least one intervention should target improvement in clinical area(s).
    - At least one intervention should target improvement in non-clinical area(s) (e.g., standing up an anxiety and depression gaps-in-care dashboard, running a community awareness campaign designed to reduce stigma and encourage screening, etc.).
6. Implement interventions, including ongoing data collection, monitoring, evaluation, and adjustment using a Plan-Do-Study-Act (PDSA) method.
7. Report on PIP progress. KAS is expected to report using best practices grounded in clear documentation and writing that identifies limitations and facilitates validation of findings.
    - Report quarterly using a Quarterly Report Form.
    - Report annually using an Annual Report Form.
8. Where possible, demonstrate sustained improvement in the performance indicators to reduce the number of members reporting symptoms of anxiety or depression "often" or "very often."

Description of PIP Interventions

KAS submitted a PIP project proposal in the summer of 2024, which was reviewed for adherence to the PIP aim and methodology. **Table 3** enumerates the PIP interventions for KAS.

Table 3: KAS PIP Interventions

Summary of Interventions
Intervention #1a: The Clinical Director will develop educational materials that explains the symptoms of anxiety and what anxiety feels like to most people so participants can better recognize them in themselves. The materials will be emailed (or mailed to those who do not use email) to participants on a semi-annual basis. **Intervention #1b:** The Clinical Director will develop educational materials that explains the symptoms of depression and what depression feels like to most people so participants can better recognize them in themselves. The materials will be emailed (or mailed to those who do not use email) to participants on a semi-annual basis. **Intervention #2a**: The Clinical Director will develop educational materials that explain the evidence based interventions to address symptoms of anxiety so participants better understand their options. The materials will be emailed (or mailed to those who do not use email) to participants on a semi-annual basis. **Intervention #2b:** The Clinical Director will develop educational materials that explain the evidence based interventions to address symptoms of depression so participants better understand their options. The materials will be emailed (or mailed to those who do not use email) to participants on a semi-annual basis. **Intervention #3a:** The Clinical Director will develop educational materials that review the assessment results, explains the symptoms of depression and anxiety, what the participant education looks like so staff can be prepared to support participants with understanding the materials, and how to connect participants with evidence based interventions to address the symptoms. The materials will be presented in person to all Behavioral Health Specialists, Clinical Specialists, and Supports Coordinators annually. Any staff who miss this training or who are hired after the training will receive the training through KAS' electronic education platform (Relias). **Intervention #3b:** The Clinical Director will assess Behavioral Health Specialists', Clinical Specialists', and Supports Coordinators' knowledge on anxiety, depression, and autism using a quiz prior to the training and after the training. The Clinical Director will perform analysis to determine if the training was effective and what areas require further education. **Intervention #4a:** The Quality Manager will work with the KHS IT team to develop an assessment dashboard. Initially, an eight step plan will be developed to track progress towards implementation. The ITM will report on how many of those steps are completed each quarter. Once implemented, the dashboard will allow clinicians to have up to date information on how participants are doing and what kind of supports they need. **Intervention #4b:** The Quality Manager will develop training materials for staff to know how to utilize the assessment dashboard. The Clinical Directors will develop training materials for staff to understand how to utilize the assessment dashboard to inform supports and treatment planning. This training will be provided in person to all Behavioral Health Specialists and Clinical Specialists annually. Any staff who miss this training or who are hired after the training will receive the training through KAS' electronic education platform (Relias).

KHS: Keystone Human Services; PIP: performance improvement project; IT: information technology; ITM: intervention tracking measure.

Conclusions and Comparative Findings

After revision to address issues identified in the first review, KAS's proposal was approved on September 30, 2024, and PIP implementation began on October 1, 2024. In September 2025, KAS submitted its year-1 report. In this report, KAS suggested that the assessment questions' reliance on 7-day timeframes may not be the most appropriate timeframe to use and suggested that ODP consider changing the timeframe to 2 weeks to align with other assessment tools. The Discussion section lacked significant insights, suggesting a need to flesh out some of the midstream measurements on intervention progress, particularly with regard to assessing actual use of the Relias® dashboard, now that it has been stood up as of year 1 Q3, as well as assessing staff competency using the dashboard. KAS noted that there was mixed progress on the performance indicators, but with little drilldown on ITM data to identify potential barriers, KAS was not in a position to make informed modifications to interventions. The EQRO validated the report's findings with the following recommendations.

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

There is **moderate confidence** that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results. The validation findings generally indicated that the credibility of the PIP results was not at risk. Strengths of the PIP include:

- KAS cited and compared national anxiety and depression prevalence among adults with autism with its members to justify maintaining its relatively high rate for the percentage of members who completed the ACAP assessment tool who reported anxiety/depression less frequently than "often (about once a day)" when averaged over the anxiety subdomain Likert items of the assessment.

- KAS successfully stood up a Relias dashboard, enabling staff to monitor progress of cases on MH assessments.

Results must be interpreted with some caution due to:

- There was still some ambiguity around barriers, particularly related to barrier 2, which left unclear whether and to what extent the corresponding intervention activities were appropriately targeting the barrier in question.
- There were gaps in measuring actual progress on intervention activities, particularly for intervention 4, which would enable the plan to isolate where barriers continue to impede progress on improving the performance indicators.

Recommendations

For intervention 2, KAS should clarify whether its barrier analysis (or its needs assessment, as discussed under Topic Selection) established that there were sufficient anxiety and depression resources for members both within the ACAP network and in the counties themselves. If this could be determined, KAS should conduct a network adequacy analysis of MH practitioners and at least prepare for the possibility of needing to add an intervention around building such capacity. Also, for intervention 2, KAS should clarify whether the "resources" available to members to address anxiety or depression were under their covered benefits or not, and if not, what kind of non-ACAP resources would the information discuss (e.g., county resources, CBOs, etc.) KAS should also consider including outreach calls to members' caregivers to confirm receipt and understanding of the information and to give members and their caregivers a chance to ask clarifying questions.

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

There is **moderate confidence** that the PIP produced evidence of improvement. For year 1, the population indicators 1 and 3 showed statistically insignificant improvement. For the individual indicators, indicator 2 for anxiety worsened somewhat, while indicator 4 for depression (increase in the number of members reporting less frequent depression) improved somewhat from baseline.

Table 4 presents the PIP performance indicator results through year 1.

Table 4: Performance Measures and Results

Performance Measure	Baseline Period	Baseline Rate	First Remeasurement Year	Second Remeasurement Rate	Sustained Improvement (Yes/No)
Indicator 1: Percentage of members who completed the ACAP assessment tool who reported anxiety less frequently than "often (about once a day)" when averaged over the anxiety subdomain Likert items of the assessment.	April–September 2024	84.2%	85.4%	N/A	N/A
Indicator 2: Percentage of participants who reported less frequent feelings related to anxiety compared to their baseline anxiety subdomain average.	April–September 2024	N/A	58.7%	N/A	N/A
Indicator 3: Percentage of members who completed the ACAP assessment tool who reported depression less frequently than "often (about once a day)" when averaged over the depression subdomain Likert items of the assessment.	April–September 2024	90.7%	91.4%	N/A	N/A

Performance Measure	Baseline Period	Baseline Rate	First Remeasurement Year	Second Remeasurement Rate	Sustained Improvement (Yes/No)
Indicator 4: Percentage of participants who reported less frequent feelings of depression compared to their baseline depression subdomain average.	April–September 2024	N/A	48.0%	N/A	N/A

KAS: Keystone Autism Services; ACAP: Adult Community Autism Program; N/A: not applicable.

IV. Validation of Performance Measures

Objectives

PA selects quality metrics and performance targets by assessing gaps in care within the state's Medicaid population. DHS monitors and uses data that evaluate the MCP's strengths and opportunities for improvement in serving the Medicaid population by specifying PMs that MCPs must include in their QAPI program. The selected PMs and performance targets are reasonable, based on industry standards, and consistent with the CMS's *External Quality Review (EQR) Protocols*. DHS conducts annual monitoring of the PMs to observe trends and to identify potential risks to meeting performance targets. Annually, the EQRO validates the MCP's QAPI PM rates.

For SFY 2025, ODP required KAS to calculate and report PMs as part of their QAPI program. IPRO validated all PMs reported by the PIHP for SFY 2025 to ensure that the PMs were implemented according to specifications and state reporting requirements (*Title 42 CFR § 438.330[b][2]*).

Technical Methods of Data Collection and Analysis

The year 2021 marked an update to performance measurement, as specified in Appendix K of the agreement. Changes were introduced to the methodology, which included an increased use of percentages and rates to facilitate more meaningful year-over-year comparisons. In most of these cases, new benchmarks and accompanying baselines were set.

Annual results were submitted by KAS to ODP in their SFY 2025 ACAP ODP Report. As part of its annual compliance review, ODP reviewed documentation related to KAS's tracking and reporting of the PMs. ODP also reviewed a sample of participant records, including ISPs, assessments, incident reports, service records, encounter forms, and medical records, along with other primary data as part of its monitoring for SFY 2025. IPRO also reviewed findings from the most recent ISCA completed in 2024.

CMS's *Protocol 2. Validation of Performance Measures* was used as the framework to validate PMs specified by PA for inclusion in the MCP's QAPI programs. **Figure 5** details the mandatory EQR Protocol 2 activities.

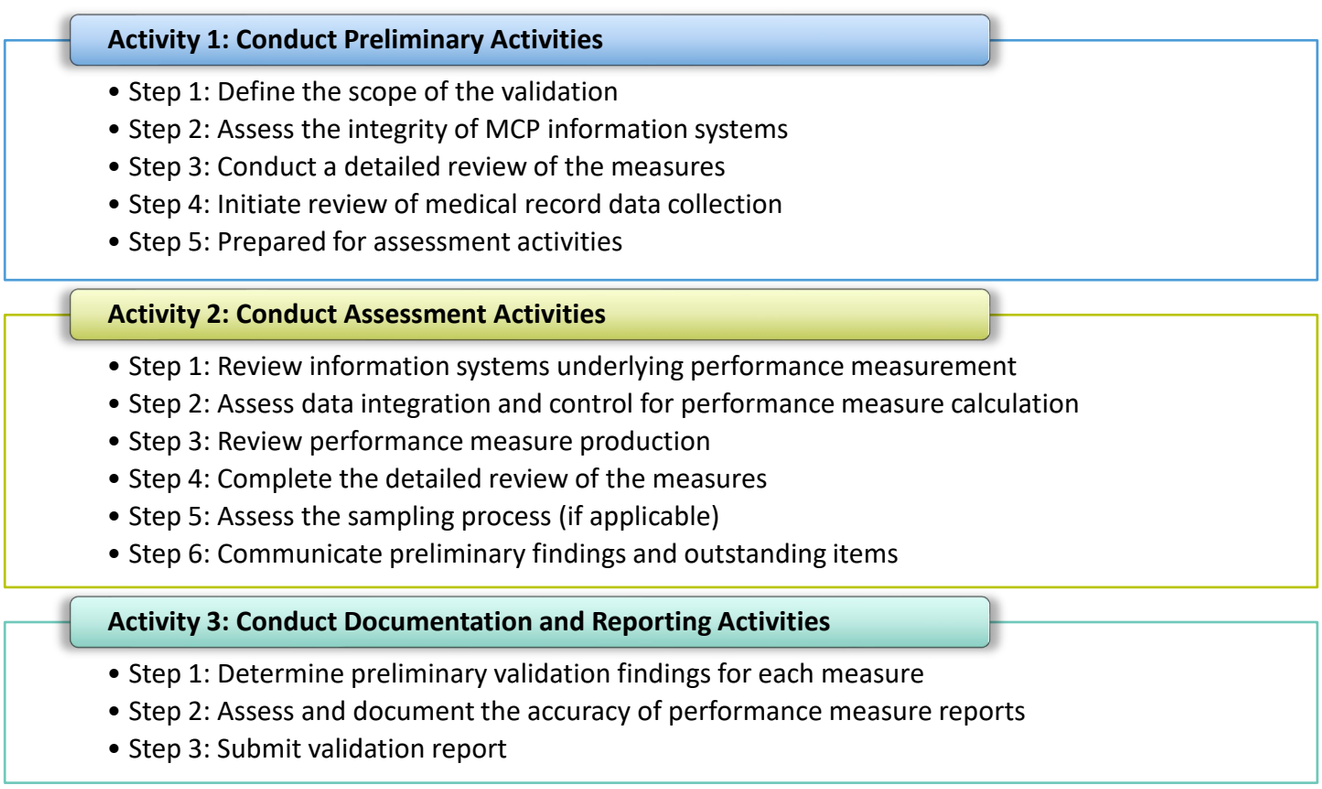


Figure 5: EQR Protocol 2 Activities MCP: managed care organization; EQR: external quality review.

Description of Data Obtained

Information Systems Capabilities Assessment

KAS underwent an ISCA in 2024. KAS reported that multiple data sources and systems were used for QAPI PM reporting. The flow of PM information was largely manual, relying on system incident records, state system for individual records, the state operated web-based survey, electronic health records (EHRs) managed through their CareLogic® platform, electronic medication records, and claims data managed through their UniData® system. KAS was found to meet all the standards under the applicable review elements of the ISCA.

ACAP QAPI performance measures were validated through a series of steps, detailed in **Figure 6**.

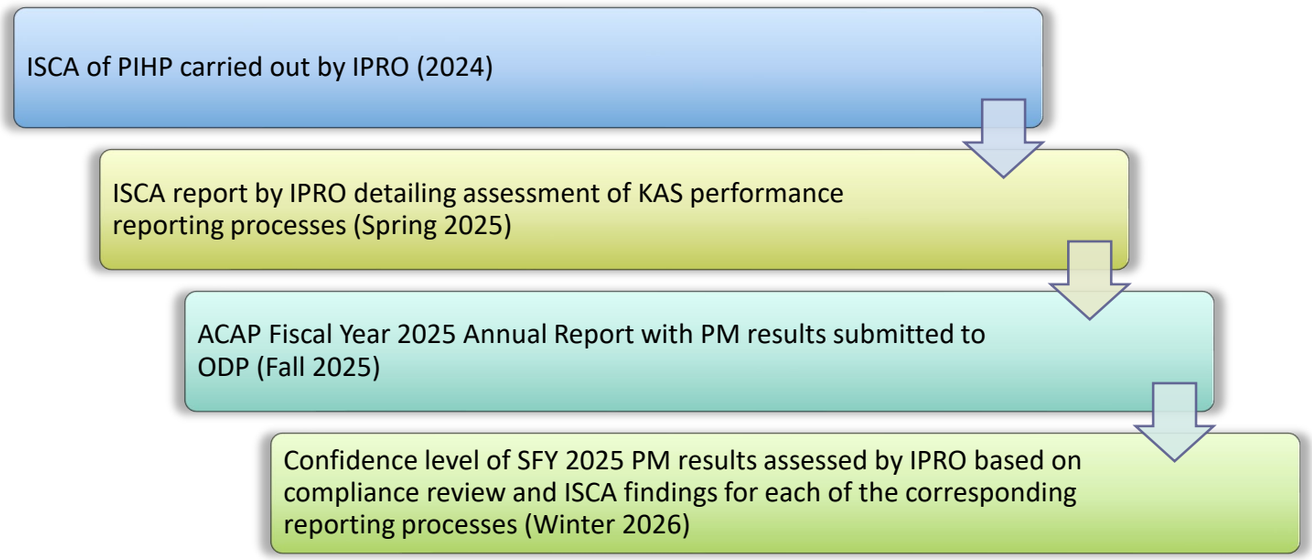


Figure 6: QAPI BH Performance Measure Validation Process MCO: managed care organization; QAPI: Quality Assessment and Performance Improvement; BH: behavioral health.

In accordance with the EQR PM validation protocol issued by CMS in February 2023, IPRO adopted a qualitative assessment of the PMs, expressed in terms of levels of confidence. **Figure 7** displays the validation determination and corresponding confidence levels.

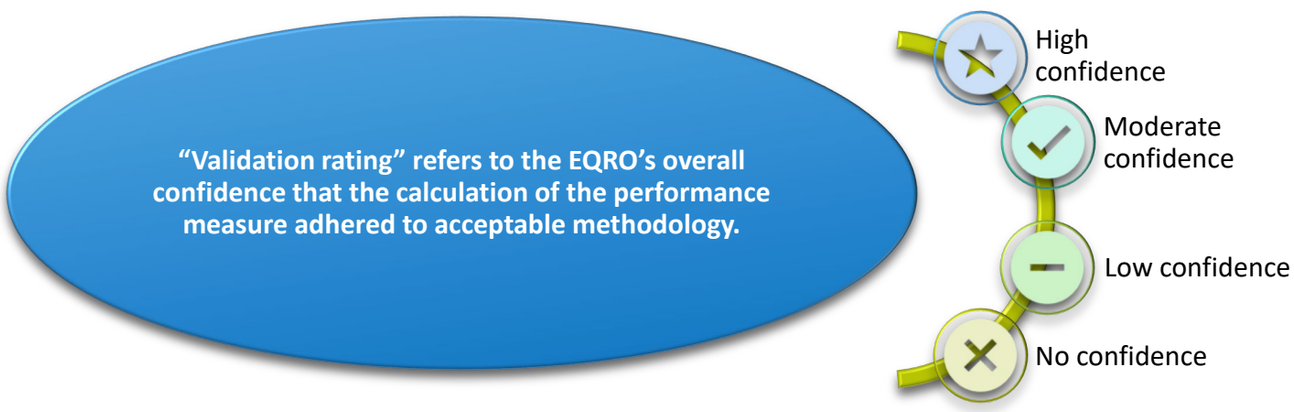


Figure 7: Validation Determination and Confidence Levels

Pennsylvania Performance Measures

Table 5 presents SFY 2025 results of ACAP PMs for which benchmarks were established.

Table 5: ACAP SFY 2025 Performance Measure Results

Performance Measure	Benchmark	Rate	Data Source/Type	Validation Rating
Law Enforcement Incidents	95% of all individuals will reduce or maintain, if at zero, their number of law enforcement incidents (charged with a crime or under police investigation) as compared to baseline.	98.9% (180 of 182) of participants	State system for incident records	High Confidence
Behavioral Health Crisis Events	95% of all individuals will reduce or maintain,	95.6% (174 of 182) of participants	State system for incident records	High Confidence

	if at zero, their number of behavioral health crisis events as compared to baseline.			
Social Isolation	34% of all individuals will decrease or maintain, if at eight, their Social Isolation score compared to baseline.	NR	State system for individual records (the Autism Supports Assessment Protocol, or ASAP)	N/A
Psychiatric Hospitalization Follow-up	95% of all psychiatric hospitalizations will be followed by a psychiatric or PCP visit within 30 days.	100% (5 of 5) of psychiatric hospitalizations	State system for incident records and electronic case records	High Confidence
(Timeliness of) Initial PCP Visit	95% of all new enrollees will have an initial visit with a PCP within 3 months prior to enrollment or within 3 weeks after enrollment.	100% (4 of 4) of participants	Electronic case records	High Confidence
Annual Dental Exam	90% of all participants will have a dental exam each calendar year.	86.0% (151 of 176) of participants	Electronic case records	High Confidence
Medication Therapeutic Management Plan (MTMP)	90% of participants with four or more psychotropic medications will have an MTMP in progress or completed.	84% (32 of 38) of participants	Electronic medication records	High Confidence
Health Risk Screening Tool (HRST)	16% of participants receiving residential habilitation services will have a decrease in their HCL score compared to their previous score.	NR	Electronic case records	N/A
Competitive Employment	56% of participants will be employed.	51.1% (92 of 180) of participants were employed in December 2024	Electronic case records	High Confidence
Employment Goals	95% of participants receiving employment services will have at least one employment goal.	100% (145 of 145) of participants	Electronic case records	High Confidence
Physical Access	95% of participants are satisfied or very satisfied with their provider's physical access, reasonable accommodation, and accessible equipment.	96% (43 of 45) of participants	Web-based survey	High Confidence

Cultural Competency	95% of participants are satisfied or very satisfied with their provider's effective and culturally competent communication	100% (45 of 45) of participants	Web-based survey	High Confidence
Feeling Valued and Heard	95% of participants are satisfied or very satisfied with feeling valued and heard by providers.	100% (45 of 45) of participants	Web-based survey	High Confidence
Person-Centered Approach	95% of participants are satisfied or very satisfied with their provider's person-centered approach	100% (45 of 45) of participants	Web-based survey	High Confidence
Goal Attainment Scale	50% of all individuals will make adequate progress on at least one of their objectives at their annual review.	67.1% (102 of 152) of participants	State operated web-based survey	High Confidence
Residential Rehabilitation	4% or less of participants will receive residential habilitation services.	3% (6 of 180) of participants	Electronic case records	High Confidence

ACAP: Adult Community Autism Program; SFY: state fiscal year; PCP: primary care provider; Medication Therapeutic Management Plan: MTMP; Health Risk Screening Tool: HRST; HCL: Health Care Level; NR: not reported; N/A not applicable.

Conclusions and Comparative Findings

KAS met its SFY 2025 QAPI performance targets for the following measures: Law Enforcement Incidents, Behavioral Health Crisis Events, Psychiatric Hospitalization Follow-up, (Timeliness of) Initial PCP Visits, Physical Access, Cultural Competency, Feeling Valued and Heard, Person-Centered Approach, Goal Attainment Scale, and Residential Rehabilitation. KAS did not meet its QAPI targets for the following measures: Annual Dental Exam, Medication Therapeutic Management Plan, and Competitive Integrated Employment.

KAS was unable to report on aggregate performance on Social Isolation and Health Care Level (HCL) scores for SFY 2025, citing several reasons. Changes to the Temple University Community Participation (TUCP) tool in July 2025 required establishing a new baseline for assessing changes in social isolation, while KAS encountered challenges with standing up the business intelligence analytics and dashboarding needed to run the Health Risk Screening Tool (HRST) measure. KAS reported that they anticipated being able to compare current and previous HCL scores in SFY 2026.

While KAS missed targets in SFY 2025 related to annual dental exams, medication therapeutic management plans, and competitive integrated employment, these areas of underperformance were not especially significant, suggesting that minor remediations may be all that is needed to meet future targets. KAS should review findings from the compliance review particularly as relates to QAPI as well as conduct targeted root cause analyses of the observed underperformance. This may entail case reviews with support teams to better understand the specific barriers that arose which might then inform more general improvements in documentation, monitoring, and follow-up.

In response to the previous recommendation that ACAP add more measurable goals to QAPI PMs, the program significantly expanded the number and types of measures being reported by the MCP, increasing to 18 metrics from nine last year. The PM set now includes quantifiable process and outcome measures of care access, timeliness, and quality at both the member and provider levels. And while the body mass index (BMI) measure was not reported for SFY 2025, KAS spent the year developing a BMI follow-up plan module in their Electronic Health Record (Carelogic) to document participants' plans for working towards a healthy BMI. KAS reports that implementation of the BMI follow-up planning measurement workflow will occur in SFY 2026.

ODP also spent SFY 2025 planning for the eventual addition of LTSS, including HCBS, PMs to its QAPI framework. Furthermore, ODP continues to set goals for their QAPI PMs to bring ACAP into closer alignment with the DHS quality strategy.

V. KAS Compliance with MMC Regulations

Objectives

This section presents a review by IPRO of the PIHP's compliance with the MMC structure and operations standards. Updates to the CMS EQRO protocols released in 2023 included updates to the 14 BBA standards that are now required for reporting. The standards that are subject to EQR review are contained in *Title 42 CFR § 438*, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E.

Technical Methods of Data Collection and Analysis

CMS's *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations* was used as the framework to determine the extent to which Medicaid and CHIP MCPs are in compliance with federal standards. **Figure 8** details the mandatory EQR Protocol 3 activities.

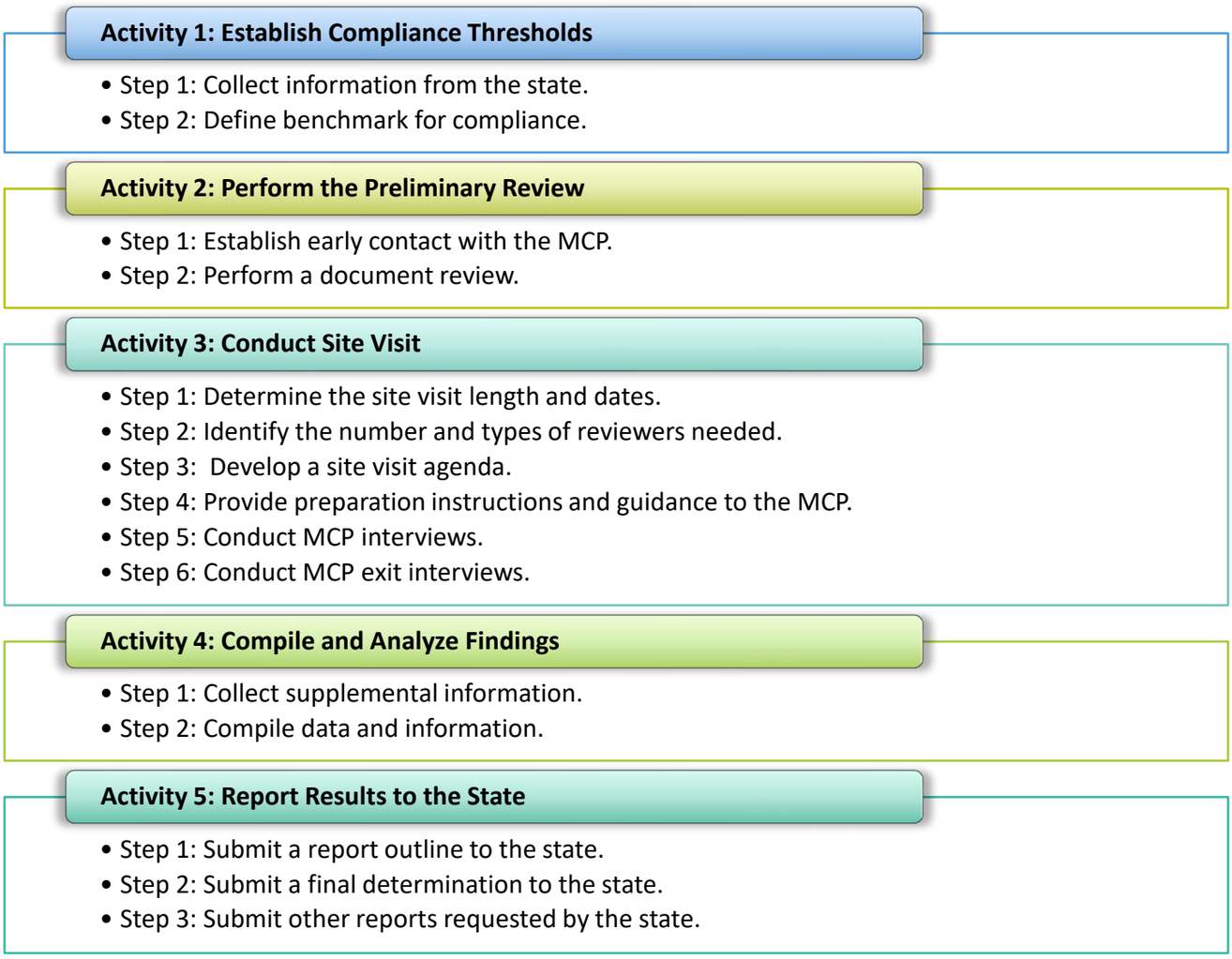


Figure 8: EQR Protocol 3 Activities MCP: managed care organization; EQR: external quality review.

KAS underwent a full triennial compliance review in 2025 for SFY 2025. Thirteen of the 14 federal standards in the applicable *Title 42 CFR* subparts were reviewed for MCP compliance. Since disenrollment in ACAP is handled by ODP, the Disenrollment category was exempted from review. Data collection consisted of IPRO requesting from KAS documentation and related evidence of compliance for the active review areas, which KAS submitted through IPRO's secure File Transfer Protocol (FTP) process. Documentation included case files for Provider Credentialing and Recredentialing under the Provider Selection standard as well as Transitions of Care (TOC) under the Coordination and Continuity of Care standard. Requests and submissions underwent several iterations to ensure relevance and completeness of information.

Data collection was followed by a desk review. The 13 active review standards were operationalized by CMS review elements that were furthermore crosswalked to pertinent standards defined in the ACAP agreement. IPRO and ODP reviewed the required review elements for the 13 standards, and elements that were already part of ODP's annual monitoring were removed from IPRO's active review to avoid duplication of effort. ODP's SFY 2025 compliance findings for the applicable elements were provided to IPRO to supplement IPRO's desk review of the remaining elements. Desk review was followed by a virtual onsite video conference with KAS leadership and staff consisting of document and system reviews and informal interviews.

For SFY 2025, KAS had the opportunity to review the initial compliance review determinations and respond with clarifications before final determinations were made.

Description of Data Obtained

Tabulated findings are formatted to be consistent with the subparts prescribed by the BBA regulations. In addition, findings for SFY 2025 are presented here under the three "CMS sections" headings: Standards including Enrollee Rights and Protections, QAPI Program, and Grievance System. Under each heading, compliance tallies for each of the 13 BBA MMC standards were produced from the compliance review data. Applicable regulatory citations are provided for each standard, consistent with the applicable subparts set out in the BBA regulations and described in EQR Protocol 3.

Table 6 summarizes the compliance review determinations across the 13 BBA MMC standards with tallies of the applicable compliance review elements that were used, by finding. Compliance levels of "Met," "Partially Met," and "Not Met" were used. Separate tallies are provided for elements that are not applicable ("N/A") or deemed compliant from a secondary source review, such as an NCQA-accreditation ("Deemed").

Table 6: KAS Compliance with MMC Standards in SFY 2025

MMC Standard	Compliance Status	N/A	Deemed	Met	Partially Met	Not Met
Standards, Including Enrollee Rights and Protections						
Assurances of Adequate Capacity and Services (*Title 42 CFR § 438.207*)	Compliant	0	0	7	0	0
Availability of Services (*Title 42 CFR § 438.206* and *§ 10[h]*)	Partially Compliant	0	0	9	1	0
Confidentiality (*Title 42 CFR § 438.224*)	Compliant	0	0	1	0	0
Coordination and Continuity of Care (*Title 42 CFR § 438.208*)	Partially Compliant	0	0	9	2	4
Coverage and Authorization of Services (*Title 42 CFR § 438.210[a–e], § 441, Subpart B,* and *§ 438.114*)	Partially Compliant	0	0	27	0	1
Disenrollment Requirements and Limitations (*Title 42 CFR § 438.56*)	N/A	9	0	0	0	0
Emergency and Post-stabilization Services (*Title 42 CFR § 438.114*)	Compliant	0	0	7	0	0
Enrollee Rights and Protections (*Title 42 CFR § 438.100*)	Partially Compliant	7	0	67	2	1
Health Information Systems (*Title 42 CFR § 438.242*)	Partially Compliant	0	0	7	2	1
Practice Guidelines (*Title 42 CFR § 438.236*)	Not Compliant	0	0	0	0	6
Provider Selection (*Title 42 CFR § 438.214*)	Partially Compliant	0	0	4	3	0
Subcontractual Relationships and Delegation (*Title 42 CFR § 438.230*)	Compliant	0	0	13	0	0
QAPI Program						
QAPI Program (*Title 42 CFR § 438.330*)	Partially Compliant	0	0	6	5	1
Grievance System						
Grievance and Appeal Systems (*Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424*)	Compliant	0	0	38	0	0

KAS: Keystone Autism Services; MMC: Medicaid managed care; SFY: state fiscal year; N/A: not applicable; CFR: Code of Federal Regulation; §: section; QAPI: Quality Assurance and Performance Improvement.

Conclusions and Comparative Findings

KAS improved compliance rates in large part by continuing to develop policies and procedures for SFY 2025 for a number of areas that previously lacked such policies and procedures.

Of the 11 standards within Standards, including Enrollee Rights and Protections, KAS was found partially compliant with 6 standards and non-compliant with 1 standard, Practice Guidelines. For Availability of

Services, language in the documents provided did not completely reflect state and federal requirements on timely access as it relates to authorization of services.

Related to Coordination and Continuity of Care, case management file reviews revealed some specific opportunities for improvement. In some cases, assessments were not conducted within stipulated timeframes, or in cases where a periodic risk evaluation (PRE) was completed, not all the risks which were identified were captured in the ISP. Specifically, issues were noted as partially compliant across domains of the ISP: Behavioral Information, Medical/Health/Safety, Functional Information, and Employment. KAS was also found partially compliant with certain policies and procedures requirements including: coordinating authorized services provided to participants between settings of care with services participants receive outside of KAS and informing both DHS and providers of members' needs to avoid duplication of services.

The deficiency in timely assessments noted under Coordination and Continuity of Care also led to a partial compliance finding for Coverage and Authorization of Services.

Under Enrollee Rights and Protections, KAS was partially compliant with two review elements and non-compliant with a third. First, KAS's current electronic provider directory does not include telehealth. Furthermore, KAS lacked a clear policy to ensure all staff and network providers who have contact with potential applicants are fully informed and understand its policies for outreach, enrollment, and disenrollment. KAS was found to be not compliant with ensuring that its policies reflected federal regulations and state contract requirements to address quality and performance indicators, including participant satisfaction. KAS concurred with the finding. Although these requirements are not yet adequately reflected in policies, KAS has been conducting participant and family satisfaction surveys since 2014 and provides this information to BSASP annually. In addition to these applicable review elements, IPRO noted in its review that KAS did not have a marketing policy or procedure that reflects both the federal regulations and state contract requirements. During SFY 2025, no formal marketing campaigns or activities were conducted throughout the fiscal year due to limited enrollment and a significant program waiting list. KAS stated they participated in outreach by delivering several presentations to various organizations and advocacy groups. These presentations were aimed at increasing awareness about the program. Internal conversations have taken place between KAS and ODP regarding the development and distribution of marketing materials. These discussions reflect the organization's efforts to address future marketing needs for its population. The applicable Section *Title 42 CFR § 438.104 Marketing activities* will be included in the next compliance review. Development of a marketing policy will help to ensure that all regulatory requirements are met and that the program remains in full compliance moving forward.

Under Health Information Systems, KAS was partially compliant with two elements and non-compliant with a third. KAS's ISCA, conducted in 2024, determined that KAS collects enrollee and provider information to enable services to plan participants and prepares encounter data reports to capture services rendered to the plan participants. During the virtual interview, KAS provided a live demonstration of its EHR system, which is used to collect participant information, and described its process for the collection and maintenance of provider information and reporting of participant encounters to ODP. However, the SFY 2025 quarterly medical services reports were missing the ZIP code of provider locations as required by the ODP agreement. In addition, as noted under Enrollee Rights and Protections, KAS's current electronic provider directory does not include telehealth. Finally, KAS was found non-compliant with ODP requirements concerning the implementation and maintenance of a secure, standards-based patient access API that allows members to access their claims and encounter information through third-party applications of their choice. KAS, however, noted in its response that standing up such an interface comes at a cost that is considerable for a program enrollment of just over 180 participants. There may, therefore, be an opportunity to work with ODP to identify funding which might support meeting this federal requirement.

KAS was not compliant with Practice Guidelines for any of the review elements. During the interview portion of the compliance review, KAS acknowledged its non-compliance with this regulation and discussed the action steps taken to comply. The KAS team has performed a breakdown of EHR diagnoses for current participants. This data-driven assessment, guided by participants' PH and BH data, will assist in establishing a baseline for identifying existing national evidence-based practice guidelines for programs serving adults living with autism. KAS provided a draft of their action plan as well as a template listing the medical/health topic, link to the guidelines, and guideline name. The executive director, along with other key medical and clinical staff, will actively participate in these efforts to fully comply with the requirements.

Under Provider Selection, KAS was found to be partially compliant with three review elements related to policies and procedures for communications, executions and terminations of provider contracts, and notifications within timeframes as stipulated by applicable federal and state standards. KAS met all provider credentialing and provider recredentialing requirements in the case files that were sampled and reviewed.

Finally, under QAPI, KAS was found partially compliant with five review elements and non-compliant with one element. The documents submitted for review consisted of policy statements and a QAPI plan that was essentially a list of indicators with a definition of terms. The policies did describe some of the roles and responsibilities of those roles, but the "plan" provided goals for only a subset of the quality indicators and did not describe a strategy or a concrete plan for achieving the goals that were defined for SFY 2025. The plan document also did not provide a "time stamp" to demonstrate it was in effect for SFY 2025. Furthermore, the utilization report submitted covered only the services provided ("covered") by KAS. During the compliance interview, KAS described the general process by which services and supports are regularly discussed with members to ensure continuing alignment with care goals and service plans. Care summaries in the member's EHR track both LTSS and other service provisions with progress notes, as well as outcome indicators tied to health and safety assessments. These check-ins by SCs, behavioral health supports (BHS), and clinical staff are complemented by regular monitoring of critical incidents, care management (CM) utilization, and satisfaction survey results. Monitoring involves regular communications with, and feedback from, the member's natural supports. However, the policies provided described the quality and appropriateness checks in only very general terms. KAS alluded to using PDSA, and its member-level audit template for SFY 2025 was provided. However, in the documentation provided, it was unclear how the PDSA cycle was implemented in SFY 2025 to monitor, evaluate, and revise its QAPI program and plan. Documentation provided was limited to single-topic discussions in quarterly Quality Management and Utilization Review (QMUR) Committee meetings.

SFY 2025 minutes of the ACAP Quality Management and Utilization Review Committee and board of directors (governing body) discussing the annual report were provided. The annual KAS report for SFY 2024 was provided, demonstrating submission to ODP. KAS also reported that no SFY 2024 CAPs were applicable to the SFY 2025 remediation period. However, no MAC minutes were provided that demonstrated presentation and discussion of the annual report to the MAC. Moreover, the *SFY 2024 Annual Report*, while including a brief "analysis" of findings for each relevant PM result, provided little in the way of recommendations for improvement. This reflects, in part, the relative absence of quantitative population-level goals or benchmarks to reference.

Review of Compliance with MMC Regulations Summary

Following summarizes the compliance findings as well as recommendations which are relevant for both KAS and ODP. Recommendations specific to the MCP are enumerated in **Table 11**.

- Overall, in SFY 2025, KAS was partially compliant with Standards, including Enrollee rights and Protections, due to partial compliance with Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Rights and Protections, Health Information Systems, Provider Selection, and QAPI. KAS was non-compliant with Practice Guidelines.
- KAS was fully compliant with the following categories: Assurances of Adequate Capacity and Services, Confidentiality, Emergency and Post-stabilization Services, Subcontractual Relationships and Delegation, and Grievance and Appeal Systems. Disenrollment Requirements and Limitations was exempted from review for SFY 2025.
- IPRO recommends that KAS expand utilization monitoring and reporting to all ACAP-covered services, including medical and BH services provided in the larger network, and reporting should cover all (both under- and over-) utilization. As long as authorizations occur in HCSIS, this may require working with ODP on a crosswalk to join in-house and PA HCSIS authorization and utilization data on unique member IDs and possibly dates of service.
- IPRO recommends that KAS continue working with ODP to develop, wherever feasible, population-level quality benchmarks for its QAPI PMs to enhance the monitoring and evaluation of the ACAP program as a whole. Improvement plans should be developed and documented in the annual (QAPI) report for areas of underperformance. The annual report should be reviewed with the MAC, and this review should be documented in the MAC meeting minutes.

VI. Validation of Network Adequacy

Objectives

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, PA contracted with IPRO to perform the validation of network adequacy for PA MCPs.

Technical Methods of Data Collection and Analysis

CMS's *Protocol 4. Validation of Network Adequacy* was used as the framework to validate network adequacy. **Figure 9** details the mandatory EQR Protocol 4 activities.

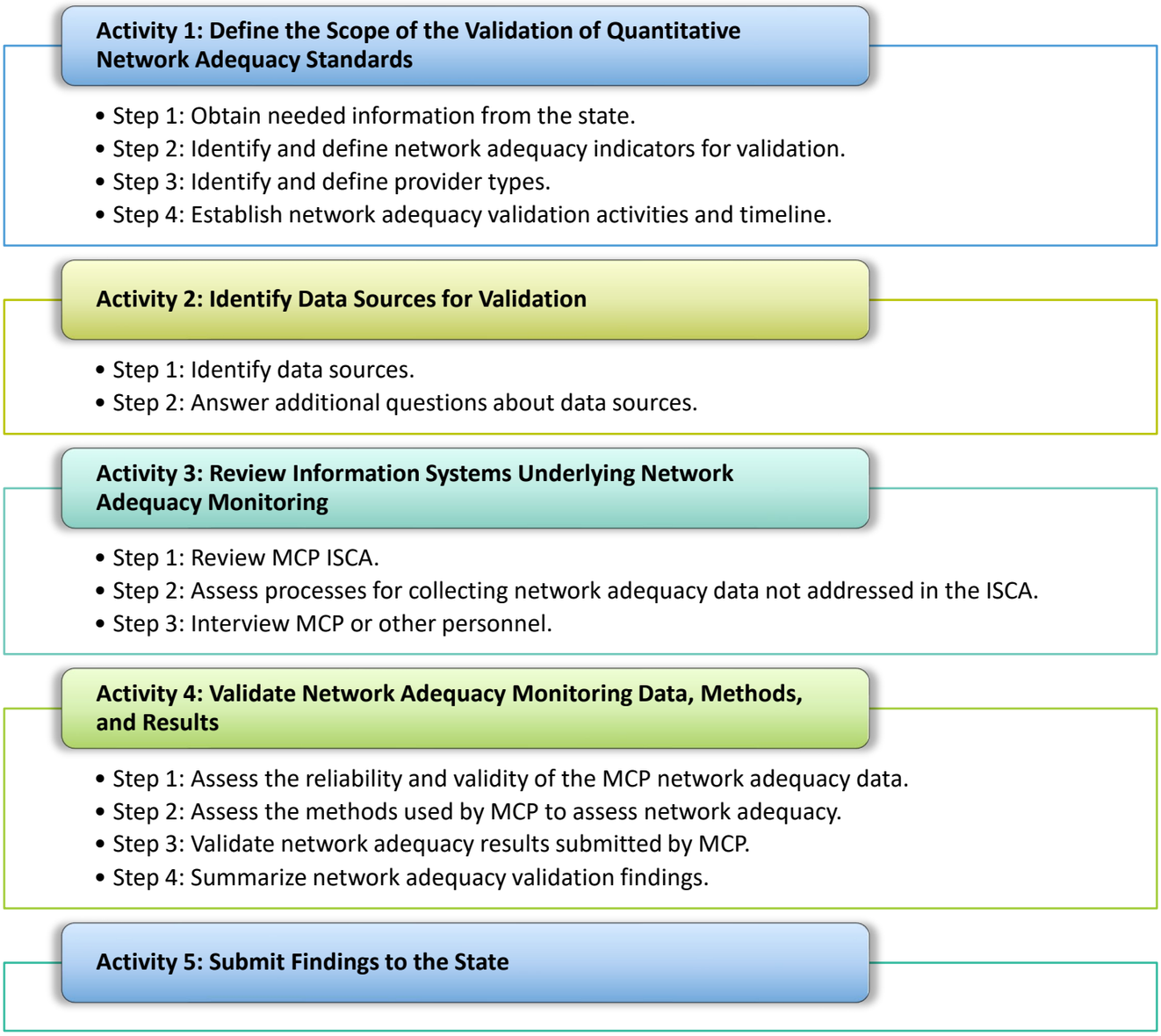


Figure 9: EQR Protocol 4 Activities MCP: managed care plan; ISCA: Information Systems Capabilities Assessment; EQR: external quality review.

Description of Data Obtained

Box 3 details the data obtained from PA that were used to conduct the validation activities and their definitions.

Box 3: Network Adequacy Data and Definitions

- **Network adequacy standard:** A quantitative parameter that states establish to set expectations for contracted managed care plans' provider networks.
- **Network adequacy indicator:** The metric(s) used to assess adherence to the quantitative network adequacy standard.
- **Applicable provider types:** All provider types to which the network adequacy standard applies.
- **Applicable regions:** All regions to which the network adequacy standard applies.
- **Data and documentation submitted by MCPs:** Data source, format, software, variables, and state standards for data accuracy, timeliness, and completion.

MCP: managed care plan.

IPRO conducted meetings with ODP to discuss the network adequacy analysis process, the process strengths, and opportunities for improvement. IPRO collected information from ODP for the network adequacy validation activities, including:

- a detailed list of the state's quantitative network adequacy standards,
- a description of network adequacy data and documentation,
- a description of the information submitted by the MCP to PA, and
- MCP network adequacy rates.

IPRO used the information collected from ODP to assess the network adequacy data sources applicable to the PIHP and determined a validation finding and rating for each network adequacy indicator.

IPRO gathered information from PA ODP to conduct preliminary network adequacy validation activities using worksheets 4.1, 4.2, and 4.3 of the 2023 CMS EQR Protocols. PA ODP completed the three worksheets, which listed and described: the network adequacy standards that were in effect for the MY (Worksheet 4.1), the quantitative indicators used to assess compliance with the network adequacy standards (Worksheet 4.2), and the data source(s) used for each indicator (Worksheet 4.3). IPRO supplemented this information using results from its ISCA conducted for KAS in 2024. Using this information, IPRO then assessed the data sources and data collection procedures for validity, including measurement validity, accuracy, and completeness. **Table 7** displays the network adequacy standards and indicators. **Table 8** summarizes the frequencies of data-reporting by the PIHP and corresponding network adequacy indicators (in short form) for provider types.

Table 7: PIHP Network Adequacy Standards and Indicators Applicable in SFY 2025

Network Adequacy Standard	Network Adequacy Indicator
The Contractor must offer Participants a choice of at least two (2) Network Providers for each service or Provider type. Providers must be within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	Proportion of participants who have two providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.
The Contractor must offer Participants a choice of at least two (2) Network Providers for each service or Provider type. For each type, at least one provider must be within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	Proportion of participants who have at least one provider within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.

Table 8: PIHP Network Adequacy Standards and Indicators by Provider Type

Applicable Provider Type	Data and Documentation Submitted (Frequency)	Network Adequacy Indicator
Physician Services	Geomapping Report: Report is run once a year as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Audiologist	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
CRNP	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Chiropractor	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Dentist	Geomapping Report: Report is run once a year as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Health Promotion	ODP review of grievances related to Access (annually)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Hospice	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Medical Supplies/DME	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Mental Health Crisis Intervention	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Non-Emergency Transportation	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes

Applicable Provider Type	Data and Documentation Submitted (Frequency)	Network Adequacy Indicator
Optometrist	Geomapping Report: Report is run once a year as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Psychiatric (Outpatient)	Geomapping Report: Report is run once a year as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Podiatrist	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Prosthetic Eye/Other Eye Appliances	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Respiratory	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
TCM	ODP review of grievances related to Access (quarterly)	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Assistive Technology	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Career Planning	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Community Transition Services	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Day Habilitation	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Family Support	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Homemaker/Chore	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Home Modifications	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Non-Medical Transportation	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Nutritional Consultation	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Personal Assistance	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Respite	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Small Group Employment	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes

Applicable Provider Type	Data and Documentation Submitted (Frequency)	Network Adequacy Indicator
	part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	
Supported Employment	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
SC Services	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Specialized Skill Development	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Therapies	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Vehicle Modifications	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
Visiting Nurse	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 2 providers within 30 minutes Rural: 2 providers within 60 minutes
ICF	ODP review of grievances related to Access (quarterly)	Urban: 1 provider within 30 minutes Rural: 1 provider within 60 minutes
Nursing Facility	ODP review of grievances related to Access (quarterly)	Urban: 1 provider within 30 minutes Rural: 1 provider within 60 minutes
Residential Habilitation	Participant Satisfaction Survey: Surveys are completed once a year and are reviewed as part of ODP monitoring. The reports are sent as PDFs to secure SharePoint.	Urban: 1 provider within 30 minutes Rural: 1 provider within 60 minutes

PIHP: prepaid inpatient health plan; SFY: state fiscal year; CRNP: certified registered nurse practitioner; ICF: intermediate care facility; DME: durable medical equipment; TCM: targeted case management; SC: supports coordination; ODP: Office of Developmental Programs.

Of the provider types covered by the ACAP maximum travel time standards, four provider types—dental, PCP, vision, and psychiatry—were monitored in SFY 2025 using complete quantitative measurement. KAS utilizes its EHR system to generate a list of participants with ZIP codes of residence. KAS also relies on a provider tracking file to identify current network providers and extract information on provider type and location. These data are then imported into the Quest Analytics® Suite software, which applies longitude/latitude geocoding to those data to produce a geo-access report. The vendor, Quest Analytics, provides technical support as needed. KAS reviews all the reports to confirm that all participants and providers are captured accurately. KAS then submits the geo-access reports to a secure SharePoint® location hosted by PA ODP, which subsequently retrieves and reviews the reports. The reports are then reviewed for access needs that are below standard. An additional four provider categories— obstetricians/gynecologists (ob/gyns), behavioral health, counseling, and medication management—were also reported using geo-access mapping, but it is not clear whether and how these categories crosswalk to the provider types specified by the existing travel time standards.

Sixteen provider types were monitored in SFY 2025 for network adequacy through ODP reviews of complaints and grievances related to access. The remaining 19 provider types were monitored for compliance through ODP reviews of participant satisfaction survey results. Compliance with the maximum travel time standard is assumed where no complaints are registered.

For geographic areas where access does not meet travel time standards, KAS continues to work on identifying Medicaid providers to bring in network, although it is noted that this can be a challenge, given the relatively small size of the current ACAP program.

Conclusions and Comparative Findings

IPRO's network adequacy conclusions and comparative findings fall under two categories: the validation of network adequacy data, processes, and methods, and the analysis of network adequacy rates to evaluate quality of, timeliness of, and access to services.

Network Adequacy Validation Findings

Box 4 describes IPRO's network adequacy assessment process and outputs.

Box 4: Network Adequacy Validation Assessment Conclusions and Definitions

After assessing the reliability and validity of the state's network adequacy data, processes, and methods used to assess network adequacy and calculate each network adequacy indicator, IPRO generated a network adequacy **validation finding** and **rating** for each standard.

- The **finding** answers the question, "Did the entity meet or exceed the standard?" The rating is based on the following scale: **met, partially met, not met.** Exceptions, where applicable, are noted.
- The **rating** reflects IPRO's overall confidence that the state used an acceptable methodology in the design, data collection, analysis and interpretation of each network adequacy indicator. The rating is based on the following scale: **high, moderate, low, and no confidence.**

Table 9 details a summary of the network adequacy findings for KAS. The finding answers the question, "Did the MCP address this indicator in its network adequacy monitoring activities?"

Table 9: Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Finding	Validation Rating
Proportion of participants who have two Physician Services providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	99.5%	High
Proportion of participants who have two Audiologist providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two CRNP providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Chiropractor providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Dentist providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	99.5%	High
Proportion of participants who have two Health Promotion providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Hospice providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two ICF providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Medical Supplies/DME providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Mental Health Crisis Intervention providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Non-Emergency Transportation providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Nursing Facility providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low

Network Adequacy Indicator	Finding	Validation Rating
Proportion of participants who have two Optometrist providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	99.5%	High
Proportion of participants who have two Psychiatric (Outpatient) providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	99.5%	High
Proportion of participants who have two Podiatrist providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Prosthetic Eye/Other Eye Appliances providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two Respiratory providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who have two TCM providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Assistive Technology providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Career Planning providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Community Transition Services providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Day Habilitation providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Family Support providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Homemaker/Chore providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Home Modifications providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Non-Medical Transportation providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Nutritional Consultation providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Personal Assistance providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Residential Habilitation providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Respite providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Small Group Employment providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Supported Employment providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low

Network Adequacy Indicator	Finding	Validation Rating
Proportion of participants who use a provider other than the Contractor that have two Supported Employment providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Specialized Skill Development providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Therapy providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	High
Proportion of participants who use a provider other than the Contractor that have two Vehicle Modification providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low
Proportion of participants who use a provider other than the Contractor that have two Visiting Nurse providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	100%	Low

KAS: Keystone Autism Services; CRNP: certified registered nurse practitioner; ICF: intermediate care facility; DME: durable medical equipment; TCM: targeted case management.

The quantitative assessments of compliance using geo-access reports for PCP, vision, dental, and psychiatric providers produce valid and reliable measurement. Assessment of compliance based on reviews of grievances related to access, however, is a more indirect method that carries limitations. Above all, this approach assumes that any and all instances where travel times exceeded the rural or urban maximum allowed times would be registered via the grievance process. Even where such grievances are registered, it is not clear whether and how such cases are confirmed. Similar limitations apply to the reliance of surveys to measure noncompliance. It is preferable that, instead of assuming compliance and looking for evidence of noncompliance, compliance be positively measured in each instance.

In response to last year's recommendations, ODP began in 2025 to prepare for expanding their geo access reporting across a larger range of provider types. In addition, ODP plans to increase the frequency of MCP geo-access reporting from annual to quarterly. At the same time, ODP is working on clarifying definitions, including provider types, to accurately measure ACAP MCP network capacity with respect to the provision of LTSS and HCBS services in a variety of settings. And in response to last year's EQR recommendations, ODP is working to clarify how post-stabilization services will be included in network adequacy monitoring, starting with rural and urban travel time standards.

In 2025, in keeping with the state quality strategy, ODP also started work on modifications to the current network adequacy and appointment wait time standards. This includes implementing a DHS-designed secret shopper program to monitor appointment wait-times. This work is continuing in 2026 to inform future MCP contract requirements that will align with relevant updates to the *CMS Final Rule* as they come into effect.

MCP-Specific Network Adequacy Recommendations

KAS was found to be partially compliant with travel time standards for physician, dental, vision, and psychiatric services in SFY 2025. Still, KAS was near (99.5%) full compliance levels for all four categories. KAS should continue to monitor geographic areas in its network where access to certain provider types is most susceptible to non-compliance based on current and projected distributions of its enrollment in order to inform its strategic planning.

State-Specific Network Adequacy Recommendations

Recommendations from last year remain in effect. ODP should put in place processes that positively measure compliance for all its indicators. Maximum travel time indicators that are currently measured by documented grievances or self-report survey responses should instead be incorporated into geo-access reporting similar to the monitoring currently conducted for physicians, optometrists, dentists, and outpatient psychiatry.

In addition, it is recommended that ODP add post-stabilization services to its monitoring for compliance with travel time standards. This will be key to ODP meeting its goal to monitor network adequacy across all four of the major types of ACAP services: emergency, routine, urgent, and post-stabilization. Finally, it is noted that ODP is currently working to modify network adequacy standards and indicators related to appointment wait times consistent with the PA Quality Strategy. As discussed above, ODP is actively engaged with further developing its network adequacy monitoring program to not only align with federal requirements but also state quality strategy objectives for MMC.

Network Adequacy Validation Summary

Figure 10 provides a summary of network adequacy validation for ACAP.

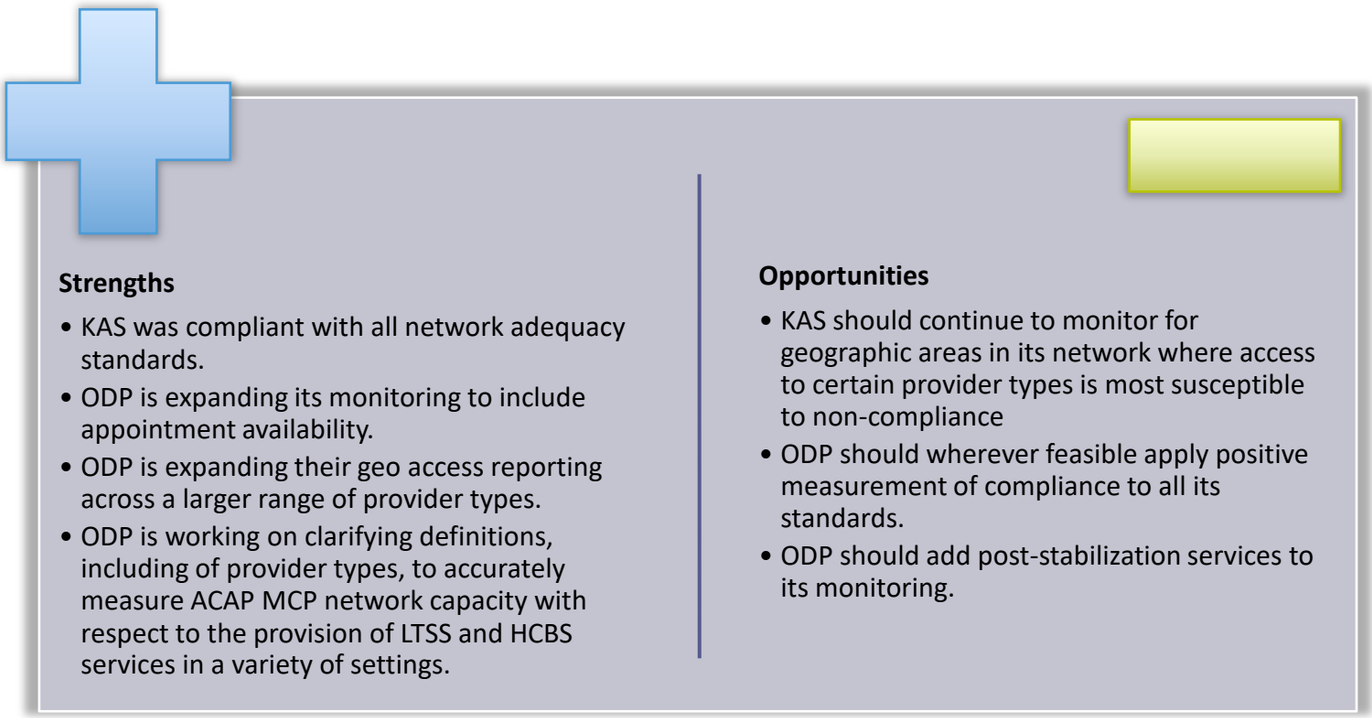


Figure 10: Network Adequacy Aggregate Findings KAS: Keystone Autism Services; ODP: Office of Developmental Programs.

VII. Assessment of MCP Responses to Opportunities for Improvement

Assessment of Quality, Timeliness, and Access

Responsibility for quality of, timeliness of, and access to health care services and supports is distributed among providers, payers, and oversight entities. That said, when it comes to improving healthcare quality, timeliness, and access, the MCP can focus on factors closer to its locus of control.

Figure 11 depicts the analysis criteria used to assess the degree to which the MCP's response has effectively addressed the recommendations during the previous year's EQR.

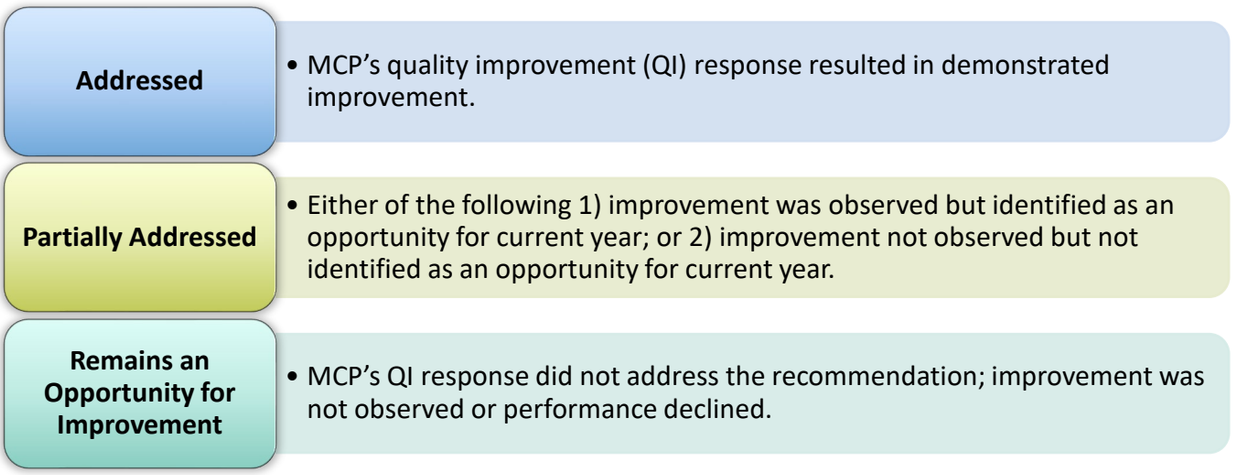


Figure 11: Assessment of MCP Response to the Previous ATR Recommendations MCP: managed care plan.

Table 10 details the full list of recommendations that were made for the PIHP for each of the applicable EQR activities in SFY 2024, as well as IPRO's assessment of KAS's response.

Table 10: KAS EQR Findings and Recommendations

Measure/Project	SFY 2024 Recommendations	SFY 2025 Finding	Assessment of Response
PIPs	N/A	KAS successfully submitted its Reducing Anxiety and Depression proposal, and implementation started October 2025.	N/A – new PIP launched in 2024
Performance Measures (Various)	KAS met its performance SFY 2024 targets for the following measures: Law Enforcement Incidents, Behavioral Health Crisis Events, Competitive Employment, and Goal Attainment Scale. KAS did not meet its targets for the following measures: Psychiatric Hospitalization Follow-up, (Timeliness of) Initial Primary Care Physician (PCP) Visits, Annual Dental Exam, Body Mass Index, and Employment Goals. KAS should consider ways to enhance lifestyle support for members, including counseling individuals and their supports around nutrition and exercise. This may start with some training for SCs and other staff. Based on the findings of ODP's annual monitoring, KAS should also strengthen alignment of ISPs with participant aspirations when setting goals, including employment goals, and this alignment furthermore should be enhanced by improved SC monitoring. This may in turn require updates to SC monitoring policies and procedures. ODP should also consider adding nationally stewarded LTSS, including HCBS, measures to its QAPI performance measure set.	KAS met its SFY 2025 QAPI performance measure (PM) targets for the following measures: Law Enforcement Incidents, Behavioral Health Crisis Events, Psychiatric Hospitalization Follow-up, (Timeliness of) Initial PCP Visits, Physical Access, Cultural Competency, Feeling Valued and Heard, Person-Centered Approach, Goal Attainment Scale, Residential Rehabilitation, and Quality and Appropriateness of Care. KAS did not meet its QAPI targets for the following measures: Annual Dental Exam, Medication Therapeutic Management Plan, Competitive Employment, and Under- and Over-Utilization.	Partially Addressed
Compliance: Coordination and Continuity of Care	Under Coordination and Continuity of Care, case reviews revealed some instances where monitoring of participant status and progress fell short of expectations related to documentation and timely follow-up. It was also noted in the Monitoring Report that there were still instances where members with four or more psychotropic medications lacked medication therapeutic management plans as required. KAS concurs with ODP's recommendation that KAS consider modifications to the Supports Coordination Monitoring Policy and Procedures that clarify who may respond to monitoring questions	KAS was partially compliant. Some of the case files reviewed did not meet ISP standards related to timeliness of relevant assessments and documentation. ODP's recommendations related to these areas were not fully addressed and remain. KAS was also found partially compliant with certain policies and procedures requirements pertaining to coordination and continuity of care.	Partially Addressed

Measure/Project	SFY 2024 Recommendations	SFY 2025 Finding	Assessment of Response
	on behalf of participants, standards of participant health and safety, and mechanisms for overseeing monthly SC contacts. KAS should ensure that medication therapeutic management plans are developed for members with four or more psychotropic medications. The monitoring mechanism should be formalized in writing as part of its QAPI plan.		
Compliance: Coverage and Authorization of Services	ODP's SFY 2024 Monitoring Report noted that there were still instances where service authorization was not completed in a timely manner, adding that KAS needed to codify what constitutes a request for service so that such requests can be documented and tracked for timely response. Numerous policies and procedures related to Coverage and Authorization of Services have been developed since the last full review by IPRO; although, as noted, opportunities for clarifying components exist. IPRO's prior recommendation, that KAS implement a tracking mechanism for all elements of authorization cases including timeliness, information on phone calls, and all correspondence, remains.	Three out of 19 participants in the ISP sample did not have all the assessments completed within the defined timeframes.	Not Addressed
Compliance: Emergency and Post-stabilization Services	KAS was found to be partially compliant with one of the two review elements under Emergency and Post-stabilization Services. Although post-stabilization services are stipulated in the Contract/Agreement, these services were not addressed in KAS's 2024 Service Authorization Policy. These services should be added. While KAS was evaluated for compliance with, and met, certain Emergency and Post-stabilization Services standards in SFY 2024, these services were not included in ODP's network adequacy monitoring for SFY 2024, so a determination could not be made whether there was a sufficient number of post-stabilization providers in or out of network where coverage was provided.	KAS was compliant in SFY 2025	Addressed
Compliance: Enrollee Rights and Protections	While KAS did formalize many of the relevant policies and procedures, KAS was found partially compliant in Enrollee Rights and Protections with respect to one requirement that it formally adopt a policy to inform members, at enrollment, of their right to	KAS was compliant with the requirement to adopt a policy to inform members, at enrollment, of their right to request information on an annual basis regarding KAS's policies and procedures on implementing advance directives (KAS was	Addressed

Measure/Project	SFY 2024 Recommendations	SFY 2025 Finding	Assessment of Response
	request information on an annual basis regarding KAS's policies and procedures on implementing advance directives. KAS should implement a policy to remind participants each year of their right to request information on advance directives. Such a policy could, for example, be specified in their current Eligibility and Enrollment policy document in the section discussing SC orientation on advance directives.	partially compliant with Enrollee Rights and Protections for unrelated reasons).	
Compliance: Practice Guidelines	KAS was found to be Not Met for one of the provisions related to adopting practice guidelines in consultation with network providers. ODP is requesting KAS to update and submit for review a revised Practice Guidelines that addresses this deficiency. In doing so, ODP points to resources which KAS can leverage, including "Appendix G: Supporting Individuals with Significant Medical Needs" of the ODP Regulatory Compliance Guide.	KAS was non-compliant with all review elements.	Not Addressed
Compliance: Provider Selection	KAS was found to be partially compliant with provision 2.5.G.h of the Agreement, that it have in place a process to trigger and implement a corrective action process with network providers when deficiencies in performance are identified. It is recommended that KAS formalize and memorialize such a process in applicable QAPI- and provider-facing documents and agreements.	KAS was compliant with the requirement to have in place a process to trigger and implement a corrective action process with network providers when deficiencies in performance are identified (KAS was partially compliant with Provider Selection for unrelated reasons).	Addressed
Compliance: QAPI Program	KAS was found partially compliant with a requirement to monitor utilization of all network and non-network covered services and that this monitoring not be limited to utilization above certain thresholds. KAS is currently taking steps to meet the requirement by collaborating with the vendor HealthAxis to monitor and report on utilization through claims data. Monitoring will furthermore integrate data on care management and HCBS services provided by KAS, as well as data from invoicing to track and report on utilization across all services provided, covered, or otherwise paid	KAS was partially compliant with the requirement to monitor utilization of all network and non-network covered services and that this monitoring not be limited to utilization above certain thresholds. As of SFY 2025, no solution had yet been found. As KAS noted in the compliance review: "KAS agrees that currently we cannot match up medical and BH utilized services with procedure codes to the authorized units in HCSIS ISPs. KAS is not sure this is possible as long as authorizations will be in HCSIS." KAS continues to work with its vendor HealthAxis to monitor and report on utilization through claims data.	Partially Addressed

Measure/Project	SFY 2024 Recommendations	SFY 2025 Finding	Assessment of Response
	for under ACAP's in lieu of covered services category. Comparison of utilization of authorized units for non-LTSS services, however, will require moving the monitoring process from the state HCSIS. KAS reports that once these steps are finalized, the mechanism for meeting this requirement will be added to relevant policies and procedures.		
Compliance: Grievance and Appeal Systems	KAS was found compliant with all applicable network adequacy standards for SFY 2025. However, ODP should put in place processes that positively measure compliance for all its indicators. Maximum travel time indicators that are currently measured by documented grievances or self-report survey responses should instead be incorporated into geo-access reporting similar to the monitoring currently conducted for physicians, ob/gyns, optometrists, and dentists. In addition, it is recommended that ODP add post-stabilization services to its monitoring for compliance with travel time standards. This will be key to ODP meeting its goal to monitor network adequacy across all four of the major types of ACAP services: emergency, routine, urgent, and post-stabilization.	KAS was compliant for this standard in SFY 2025.	Addressed
Network Adequacy – Maximum travel times (two or more providers, by type)	No recommendations for KAS were made last year related to network adequacy.	KAS was found to be partially compliant with travel time standards for physician, dental, vision, and psychiatric services in SFY 2025. Still, KAS was at near (99.5%) compliance levels for all four categories and was found fully compliant on travel time standards for all remaining provider types.	N/A

KAS: Keystone Autism Services; EQR: external quality review; SFY: state fiscal year; PIP: performance improvement project; N/A: not applicable; SC: supports coordinator; ODP: Office of Developmental Programs; LTSS: long-term supports and services; HCBS: home- and community-based services; QAPI: quality assessment and performance improvement; ISP: individual support plan; ACAP: Adult Community Autism Program; HCSIS: Home and Community Service Information System; ob/gyn: obstetrician/gynecologist.

VIII. MCP Strengths, Opportunities for Improvement, and Recommendations

Table 11 summarizes MCP SFY 2025 strengths, opportunities for improvement, and recommendations for the areas with identified opportunities for improvement. The table thereby summarizes progress over previous year, current review year findings, and recommended actions.

Table 11: KAS EQR Recommendations

Measure/Project	Finding and Recommendation	Quality	Timeliness	Access
PIP	A new PIP, Reducing Anxiety and Depression, started in October 2024, and KAS submitted its year-1 report September 2025. IPRO validated the report's findings. IPRO gave the report a moderate confidence rating for adherence to methodological standards (Rating 1) and a rating of moderate confidence (Rating 2) that the PIP demonstrated improvement from baseline.	✓	✓	✓
Performance Measures	KAS met its SFY 2025 QAPI performance measure (PM) targets for the following measures: Law Enforcement Incidents, Behavioral Health Crisis Events, Psychiatric Hospitalization Follow-up, (Timeliness of) Initial PCP Visits, Physical Access, Cultural Competency, Feeling Valued and Heard, Person-Centered Approach, Goal Attainment Scale, Residential Rehabilitation, and Quality and Appropriateness of Care. KAS did not meet its QAPI targets for the following measures: Annual Dental Exam, Medication Therapeutic Management Plan, Competitive Employment, and Under- and Over-Utilization. KAS should review findings from the compliance review particularly as relates to QAPI as well as conduct targeted root cause analyses of the observed underperformance. This may entail case reviews with support teams to better understand the specific barriers that arose which might then inform more general improvements in documentation, monitoring, and follow-up.	-	✓	✓
Compliance: Assurances of Adequate Capacity and Services	KAS was found compliant.	✓	✓	✓
Compliance: Availability of Services	KAS was partially compliant. IPRO's SFY 2024 recommendation, that KAS implement a tracking mechanism for all elements of authorization cases including timeliness, information on phone calls, and all correspondence, remains. IPRO recommends that KAS ensure that all applicable federal and state language requirements are reflected consistently across its policies and procedures, including for appointment wait times in specific scenarios. KAS should review its policies and procedures annually, making revisions as necessary to ensure alignment with both federal regulations and state contract requirements. Accordingly, when entering into a new state contract, KAS is advised to conduct a comprehensive review and update of all policies to ensure ongoing compliance.	✓	✓	✓
Compliance: Confidentiality	Compliant	✓	✓	✓
Compliance: Coordination and Continuity of Care	KAS was partially compliant. Some of the case files reviewed did not meet ISP standards related to timeliness of relevant assessments and documentation. ODP's recommendations related to these areas were not fully addressed and remain. KAS was also found partially compliant with certain policies and procedures requirements pertaining to coordination and continuity of care. KAS should coordinate authorized services provided to participants between settings of care with services participants receive outside of KAS. KAS should also develop a policy to specify that the SCs assist participants with obtaining and	✓	✓	✓

Measure/Project	Finding and Recommendation	Quality	Timeliness	Access
	coordinating needed covered services and other services, as well as housing, medical, social, vocational, and other community services, regardless of funding source, and the service includes both the development of an ISP and ongoing supports coordination. KAS should develop a workflow to ensure that all members receive development of an ISP and ongoing supports coordination. In addition, KAS should develop a policy and procedure to inform all providers and the ODP, as necessary, of the participant's needs as identified by the contractor and the authorized services delivered to the participant to prevent duplication of activities.			
Compliance: Coverage and Authorization of Services	See Availability of Services.	✓	✓	✓
Compliance: Disenrollment	N/A	-	✓	-
Compliance: Emergency and Post-stabilization Services	Compliant	✓	✓	✓
Compliance: Enrollee Rights and Protections	KAS was partially compliant with two review elements and non-compliant with a third. KAS should enhance the electronic directory by adding information about the availability of telehealth services. KAS should develop a policy to ensure all staff and network providers who have contact with potential applicants are fully informed and understand its policies for outreach, enrollment, and disenrollment. Finally, the EQRO recommends that KAS update policies and program objectives that reflect federal regulations and state contract requirements to address KAS's quality and performance indicators, including participant satisfaction.	✓	✓	✓
Compliance: Health Information Systems	KAS was partially compliant with two review elements and non-compliant with a third. KAS should add ZIP code information to provider location in its quarterly medical services reports. Furthermore, KAS should add telehealth availability as an element to their publicly available provider directory tool. Finally, KAS should implement a standards-based patient API that allows participants to access their claims and encounter information through third-party applications of their choice. KAS should work with ODP to identify potential funding which might support meeting this federal requirement.	✓	✓	✓

Measure/Project	Finding and Recommendation	Quality	Timeliness	Access
Compliance: Practice Guidelines	KAS was not compliant for all review elements. The EQRO recommends that KAS further develop its Practice Guidelines Policy to reflect the process and mechanisms involved in the application, utilization, review, and education of its guidelines and to encourage provider participation. KAS should consider posting practice guidelines on its website for provider access. Guidelines should be made available, upon request, to participants and applicants. KAS should develop additional written policies and procedures that address assurances of timely resolution of authorization requests, decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply and are consistent with the guidelines as stated in the federal regulations and state contract requirements.	✓	-	-
Compliance: Provider Selection	KAS was partially compliant. KAS met all provider credentialing and provider recredentialing requirements in the case files that were sampled and reviewed. However, KAS should develop and update, as needed, policies and procedures for communications, executions and terminations of provider contracts, and notifications within timeframes as stipulated by applicable federal and state standards.	✓	✓	✓
Compliance: Subcontractual Relationships and Delegation	Compliant	✓	✓	✓
Compliance: QAPI Program	KAS was partially compliant with five review elements and non-compliant with one review element of this standard, with deficiencies centering on the robustness of KAS's QAPI plan and process. IPRO recommends that KAS develop a strategic plan to achieve its QAPI goals. The plan should have a 1-year timeline at a minimum and ideally a longer-term horizon as well (e.g., 5-year plan). The goals and plan should cover all relevant quality indicators in the QAPI PM set, as well as other relevant QAPI KPIs that KAS develops to track progress on the QAPI PMs. KAS should leverage Keystone Human Services (KHS) operations for QAPI plan templates to use. The plan should lay out the roles and responsibilities across units, departments, committees, and any delegated functions of its QAPI activities, methods (and frequency) for data collection (including audits and case file reviews) and data quality assurance, and a data analysis plan, for each of the major QAPI areas defined by the PMs. The plan should cover all aspects of healthcare quality, access, and timeliness, and should include measures of member satisfaction. The plan should describe how QAPI will be implemented, monitored, and evaluated to include participant and provider perspectives and inputs, including through its proper governance processes, describing how goals and priorities will be developed, how improvement and remediation activities will be monitored, and mechanisms for reporting and follow-up. Processes should conform to existing ancillary requirements, including timely review of progress of CAPs through the MAC and the board of directors. Formalization of the plan should be documented in appropriate records, including any minutes, and version history tracked on the plan document itself.	✓	✓	✓

Measure/Project	Finding and Recommendation	Quality	Timeliness	Access
	IPRO recommends that KAS expand utilization monitoring and reporting to all ACAP-covered services, including medical and BH services provided in the larger network, and reporting should cover all (both under- and over-) utilization. As long as authorizations occur in HCSIS, this may require working with ODP/BSASP on a crosswalk to join in-house and PA HCSIS authorization and utilization data on unique member IDs and possibly dates of service. IPRO recommends that KAS document in its relevant policies, in concrete terms, the mechanism to assess the quality and appropriateness of care furnished to all participants, including those with special health care needs and those who need LTSS. This mechanism, if relevant, should be described in the larger QAPI strategic plan. IPRO recommends that KAS continue working with ODP to develop, wherever feasible, population-level quality benchmarks for its QAPI PMs to enhance the monitoring and evaluation of the ACAP program as a whole. Improvement plans should be developed and documented in the annual QAPI report for areas of underperformance. The annual report should be reviewed with the MAC, and this review should be documented in the MAC meeting minutes.			
Compliance: Grievance and Appeal Systems	Compliant	✓	✓	✓
Network Adequacy	KAS was found to be partially compliant with travel time standards for physician, dental, vision, and psychiatric services in SFY 2025. Still, KAS was at near (99.5%) compliance levels for all four categories and was found fully compliant on travel time standards for all remaining provider types. KAS should continue to monitor geographic areas in its network where access to certain provider types is most susceptible to non-compliance based on current and projected distributions of its enrollment in order to inform its strategic planning.	✓	✓	✓

KAS: Keystone Autism Services; EQR: external quality review; PIP: Performance Improvement Project; SFY: state fiscal year; SC: supports coordinator; ODP: Office of Developmental Programs; LTSS: long-term supports and services; HCBS: home- and community-based services; QAPI: quality assessment and performance improvement; ISP: individual support plan; EQRO: external quality review organization; API: application programming interface; PM: performance measure; KPI: key performance indicator; CAP: corrective action plan; MAC: Member Advisory Committee; ACAP: Adult Community Autism Program; BH: behavioral health; HCSIS: Home and Community Service Information System; BSASP: Bureau of Supports for Autism and Special Populations; PA: Pennsylvania; ID: identification.