Medical Assistance Quality Strategy for Pennsylvania

April 20, 2017
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I. Introduction

Preface

The Medical Assistance Quality Strategy for Pennsylvania is a technical document required by the Code of Federal Regulations, 42 CFR § 438.202\(^1\), and the Centers for Medicare and Medicaid Services (CMS) to ensure the access to high quality and efficient health care by the managed care organizations contracted by the Pennsylvania Department of Human Services (DHS). It is not intended to describe all the activities that DHS undertakes to assure the quality of care rendered to Pennsylvania Medicaid beneficiaries.

Pennsylvania currently operates a statewide, fully-capitated managed care program, called the HealthChoices program, that includes five behavioral health managed care organizations (BH-MCOs) and eight physical health managed care organizations (PH-MCOs) operating under the CMS-approved 1915(b) waiver authority. In 2009, DHS obtained approval for a Prepaid Inpatient Health Plan (PIHP) under the 1915(a) authority to create the Adult Community Autism Program (ACAP) in four counties. This Quality Strategy will describe the initiatives required to comply with 42 CFR § 438.200 and activities of all of the above programs.

What Is the Department of Human Services?

DHS provides services to over 2.3 million Pennsylvanians. DHS’ vision is to see Pennsylvanians living safe, healthy, and independent lives. Its mission is to improve the quality of life for Pennsylvania’s individuals and families. It promotes opportunities for independence through services and supports while demonstrating accountability for taxpayer resources. DHS consists of nine program offices. Eight offices (Children’s Health Insurance Program, Office of Income Maintenance, Office of Medical Assistance Programs, Office of Mental Health and Substance Abuse Services, Office of Developmental Programs, Office of Children, Youth and Families, Office of Long-Term Living, and the Office of Child Development and Early Learning) administer services that provide care and support to Pennsylvania’s most vulnerable citizens. DHS’ ninth office, the Office of Administration, functions in administrative support. In November 2014, the Department of Public Welfare was renamed the Department of Human Services. The DHS’ Organizational Chart and Responsibilities follows.

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\(^1\) References in the quality strategy are to the prior version of the Medicaid managed care regulations. States are not required to comply with the current regulations on the managed care state quality strategy until July 1, 2018 and will not be held to be out of compliance with the current version of the Medicaid managed care regulations as long as the state is complying with the prior version of the regulations. See 81 FR at 27499.
The **Office of Administration**’s (OA) primary function is administrative support. The OA is responsible for supports such as human resources, hearings and appeals, information technology, and other administrative support services.

The **Office of Income Maintenance** (OIM) serves low-income Pennsylvanians through cash assistance programs such as Temporary Assistance to Needy Families (TANF), employment and training programs, the Supplemental Nutrition Assistance Program (SNAP), home heating assistance, and assistance programs for refugees and the homeless.

The **Office of Medical Assistance Programs** (OMAP) is responsible for purchasing health care for more than 2.3 million Pennsylvania residents and enrolling Medical Assistance (MA) providers who administer the care. OMAP works closely with these providers to process their claims, establish rates and fees, and contract and monitor managed care organizations.
The **Office of Mental Health and Substance Abuse Services** (OMHSAS) is responsible for the oversight of the county mental health programs, the management of the state mental hospital system and the South Mountain Restoration Center for long-term care, and contracting for mental health and substance abuse services for MA-eligible individuals under the HealthChoices Behavioral Health Services managed care contract agreement.

The **Office of Developmental Programs** (ODP) works with individuals and families to provide supportive services and care for people with cognitive disabilities, especially intellectual disabilities and autism.

The **Office of Children, Youth and Families** (OCYF) supports the provision of quality services and best practices designed to ensure the safety, permanency, and well-being of Pennsylvania’s Children, Youth and Families.

The **Office of Long-Term Living** (OLTL) is responsible for the statewide administration of Pennsylvania’s long-term living programs and services, including nursing facility providers and home and community-based providers and their related services. Additionally, OLTL is responsible to ensure that MA eligible individuals in need of long-term care have access to needed services and that the services offered in the delivery system are used appropriately and in a manner consistent with all applicable federal and state requirements.

The **Office of Children’s Health Insurance Program** (CHIP) is designed to provide insurance coverage to children whose families earn too much to qualify for MA, but who could not afford to purchase private insurance. The office ensures that all CHIP-covered children have access to primary and preventive care through a primary care provider (PCP), as well as providing a benefit package that covers access to medically necessary health care through an MCO’s coordinated network of specialists, facilities, and other health care providers, including behavioral health providers.

The **Office of Child Development and Early Learning** (OCDEL) focuses on creating opportunities for the commonwealth’s youngest children to develop and learn to their fullest potential through a framework of supports and systems that help ensure that children and their families have access to high quality services.

DHS is focused on helping Pennsylvanians achieve safe, healthy, and independent lives. Our responsibility to Pennsylvanians includes providing services and supports in a safe environment. We are responsible for providing oversight, monitoring, and licensing of our providers, caregivers, and residential settings to ensure that each individual receiving services is in an environment that protects the well-being of our citizens. We are responsible for providing services and supports that promote the health of individuals and families in need through the receipt of medical and dental services, waiver programs, and Early Intervention services. We believe that services should lead to improved health outcomes and help to position Pennsylvanians receiving DHS services to become healthier over the course of their lives. DHS seeks to provide
services that help individuals and families become self-sufficient. We offer services and supports to assist in activities of daily living, TANF, education, employment, and subsidized child care services. Similar to health outcomes, DHS believes that self-sufficient outcomes are an important step for all Pennsylvanians. This allows DHS to achieve CMS' “Triple Aim” of improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations.

**Historical Background**

For several decades, Pennsylvania has been a leader of health care delivery reform. Pennsylvania has provided some form of managed care to the MA population since the 1970s. The early form of voluntary managed care in the MA program was available in certain Pennsylvania counties. Most of the MCOs that opted to serve MA beneficiaries under the voluntary program already operated commercial plans in that county.

After piloting a voluntary program for several years, DHS proposed to pilot a mandatory model of managed care, HealthPASS. HealthPASS was implemented in 1986 and served a 10-district area in Philadelphia under a federally-approved 1915(b) waiver of some of the normal Medicaid program requirements. Through the experience of HealthPASS, DHS proved that mandatory managed care plans could work in partnership with the commonwealth. The program was able to guarantee enough beneficiaries to ensure a financially viable business opportunity for a managed care plan while improving quality of care and enhancing beneficiaries’ access to providers.

Mandatory managed care, with its emphasis on coordination and assignment of risk to the MCO, seemed the best solution for Pennsylvania's MA program. After a thorough evaluation of the alternatives, DHS made the decision to transition to a statewide mandatory managed care program for MA beneficiaries utilizing a zone phase-in approach. To emphasize the beneficiaries’ participation in health care decisions, the program was called HealthChoices.

Three specific goals were established, which set the tone for how the HealthChoices program would be structured:

1. Improve access to health care services.
2. Improve quality of care for MA clients.

Unlike some states which implemented mandatory managed care for Medicaid statewide in a short period of time, DHS chose to implement HealthChoices incrementally in different geographic zones of Pennsylvania over a period of time, from 1997 to 2013. DHS researched and considered natural service patterns in order to define the zones. (Please see maps on pages 14 and 38.)

HealthChoices operates in all 67 counties within the commonwealth, with a high degree of coordination between the BH-MCOs and PH-MCOs. As of October 2014, there are
five BH-MCOs that are delegated contractual authority through the counties or directly contract with OMHSAS to serve about 2.3 million MA beneficiaries including Medicaid and Medicare eligible (MME) beneficiaries. OMHSAS has oversight of the behavioral health HealthChoices program that will be described in section I.A.ii. There are eight PH-MCOs that serve about 2.2 million MA beneficiaries with the exclusion primarily of adult MME beneficiaries and those residing in long-term care facilities for more than 31 days. OMAP has oversight of the physical health HealthChoices program that will be described in section I.A.i. Both OMAP and OMHSAS work collaboratively to ensure that both PH- and BH-MCOs deliver high quality coordinated care focused on the total well-being of the beneficiaries served. OMAP and OMHSAS assure their respective MCOs operate with a collaborative approach through common quality strategies, contractual requirements for coordination of care, and health information exchange.

DHS obtained approval in August, 2009 of a PIHP under the 1915(a) authority to create the ACAP. ACAP was the first program in the nation to use a single home and community-based services (HCBS) provider, Keystone Autism Services (KAS), to provide an integrated system of care as a traditional managed care organization. ACAP was designed as an integrated service delivery system to provide physical, behavioral, and community-based services to adults with autism. Participants in ACAP are adults 21 years of age or older, financially eligible for MA, possessing a diagnosis of autism, and certified as meeting MA program clinical eligibility for an Intermediate Care Facility (ICF). KAS, a subsidiary of Keystone Human Services, functions as a service provider as well as the MCO. ACAP serves participants in Cumberland, Dauphin, Chester, and Lancaster Counties in Pennsylvania. ODP provides oversight of ACAP through its Bureau of Autism Services (BAS) as described in Section I.D.

CHIP moved from the Pennsylvania Department of Insurance (PID) to DHS effective with a change in state law on December 20, 2015. This law extends CHIP through 2017 and children enrolled in CHIP continue to receive health care benefits because of the extension. CHIP covers uninsured kids and teens up to age 19 who are not eligible for MA and do not have other health insurance. The program continues to provide quality health insurance to Pennsylvania children and covers routine checkups, prescriptions, hospitalization, dental, eye care, and more.

Community HealthChoices (CHC) is a new initiative that will be implemented in 2018 and will impact older Pennsylvanians receiving long-term services and supports (LTSS) paid for by the state and Pennsylvanians receiving both Medicare and Medicaid. CHC is being developed to (1) improve access and coordination of medical care and; (2) create a person-driven, long-term support system in which people have choice, control, and access to a full array of quality services that provide independence, health, and quality of life.

Under CHC, managed care organizations will provide physical health care and long-term services and supports for older people, people with physical disabilities, and others who are receiving both Medicare and Medicaid. LTSS help individuals to perform daily
activities in their home such as bathing, dressing, preparing meals, and administering medications.

**Quality Strategy Process**

The Quality Strategy will serve to ensure that DHS’ managed care programs described above are in contract compliance, have committed resources to perform the monitoring and ongoing quality improvement, and contribute to the improvement of health for the MA population. DHS has implemented various quality improvement initiatives to increase the quality of care for the MA population. These include key initiatives such as: value-based purchasing focused on reducing preventable admissions and readmissions, increased preventative dental services for children, coordinated physical health and behavioral health quality improvement projects, MCO and provider pay for performance (P4P) programs, wider implementation of community-based care management teams, and patient-centered medical homes (PCMH).

DHS sought input on its Quality Strategy from its Medical Assistance Advisory Committee (MAAC) as well as its Consumer and Managed Care Sub-committees. The MAAC advises DHS on issues of policy development and program administration. The MAAC is composed of citizens of the commonwealth with experience, knowledge, and interest in the delivery of health care services to low income citizens and medically vulnerable groups. DHS also sought feedback through structured discussions with various constituents involved in the specific programs of OMAP, OMHSAS, ODP, and OLTL. These meetings provided a forum for ongoing communication between DHS and constituents to share their key quality priorities. The Quality Strategy was also distributed for stakeholder comment through the OMHSAS Planning Council. This advisory group includes beneficiaries, providers, HCBH Primary Contractors, BH-MCOs, and representative organizations. Lastly, DHS sought public comment through posting a Public Notice. The public was allotted 30 days to review and comment.

DHS views the Quality Strategy as a dynamic document that needs to be updated as each of the programs described above develop and change over the course of a year. Ongoing review of the Quality Strategy is necessary because of rapid time quality improvement techniques and the leverage of more real time quality measurement through health information exchange. DHS is committed to ensuring its programs exceed the standards set forth within the External Quality Review Organization (EQR) regulations. More importantly, DHS is committed to objectively demonstrating that their programs assure beneficiaries timely access to essential services and high quality of care in a cost-effective manner. The Quality Strategy will be posted on DHS’ web site as updated for public comment. All feedback will be considered in the review of the Quality Strategy.
A. HealthChoices

i. Office of Medical Assistance Programs (OMAP) Quality Strategy

1. Introduction

OMAP’s mission is to improve the quality of life for Pennsylvania’s individuals and families. We promote opportunities for independence through services and supports while demonstrating accountability for taxpayer resources.

OMAP’s Mission:

Service - We will provide responsive, timely, and quality service to beneficiaries and stakeholders (families, providers, advocates, employees, and business partners).

Partnership - We will recognize the needs of beneficiaries and stakeholders through the use of open and public input and feedback processes.

Stewardship - We will be prudent and efficient in our use of public resources.

Innovation - We will seek and adopt creative solutions to improve performance.

Respect - We will value different perspectives and appreciate the contributions of all beneficiaries, stakeholders, and employees.

OMAP administers the joint state/federal MA (also known as Medicaid) program that purchases health care for more than 2.3 million Pennsylvania residents and enrolls MA providers who administer the care. OMAP purchases services through contracts with PH-MCOs and under an indemnity, or traditional, fee-for-service system. Facility-based services are reimbursed under case-mix for long-term care for the elderly, while other facilities are paid on a prospective, or cost, basis. OMAP is also responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting and monitoring of PH-MCOs, and detecting and deterring provider and beneficiary fraud and abuse. Following is an overview of OMAP and its bureaus that administer the MA program.

<table>
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<tr>
<th>Deputy Secretary for OMAP</th>
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<tr>
<td>• Deputy Secretary</td>
<td>• Bureau of Policy, Analysis and Planning</td>
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<td>• Office of Clinical Quality Improvement</td>
<td>• Bureau of Fee-for-Service Programs</td>
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<td>• Chief Medical Director</td>
<td>• Bureau of Data and Claims Management</td>
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<td>• Chief Dental Director</td>
<td>• Bureau of Managed Care Operations</td>
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<td>• Bureau of Fiscal Management</td>
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Deputy Secretary’s Office (DSO):

The deputy secretary plans, coordinates, and directs the provision of benefits and services throughout the commonwealth; consults and cooperates with federal and state government, private agencies, and associations on the delivery of medical services to ensure that the quality of and access to these services are in compliance with federal and state regulations and resources; and recommends changes in law and regulations for MA programs. The deputy secretary provides the leadership and direction necessary to develop and coordinate OMAP’s Quality Management (QM) program. The deputy secretary delegates responsibility for the implementation of the QM plan to the medical director. However, ultimate accountability for the quality of care and services given to members is retained by the deputy secretary.

Office of Clinical Quality Improvement (OCQI):

The OCQI is responsible for the development and implementation of a centralized clinical quality improvement program for services delivered primarily by OMAP’s Bureau of Fee-for-Service Programs and Bureau of Managed Care Operations. The OCQI assists in the planning, direction, coordination, and evaluation of the clinical quality improvement goals and objectives defined by OMAP. The OCQI works collaboratively with all OMAP bureaus to monitor and evaluate OMAP’s comprehensive quality improvement strategies and ensure compliance with federal and state requirements for evaluating performance in access, quality, and appropriateness of clinical service delivery. The staff of OCQI helps to identify: a.) barriers to care; b.) ways to improve access to care for MA beneficiaries; and c.) ways to engage providers in the MA program. OCQI staff are responsible for implementing the ARRA HITECH meaningful use electronic health record initiative. OCQI interacts with other state agencies involved in health information exchange. The staff is focusing on improving technology for our providers to enhance the delivery of quality care and improve efficiency. OCQI has developed the strategic roadmap for leveraging health information technology to electronically report on and improve the quality of health care for MA beneficiaries.

Bureau of Data and Claims Management (BDCM):

The BDCM is responsible for providing leadership in the support and development of innovative technological solutions to all stakeholders of OMAP’s health care programs by: developing and managing systems to support mandatory managed care and fee-for-service programs; providing information technology support to OMAP; leading OMAP in the development of technology to support providers, beneficiaries, and business partners; ensuring that OMAP’s systems and technology provide maximum support for the MA program today and into the future; and servicing health care providers through efficient and accurate processing of claims and data. The BDCM is divided into two divisions: the Division of Managed Care Systems Support and the Division of MAMIS Support.
Bureau of Fee-For-Service Programs (BFFSP):

The BFFSP is responsible for the operational components of OMAP’s FFS health care delivery program to include the following:

1. Provides medical review of services under FFS including prior authorization, program exception, and benefit limit exception for pharmacy, dental/orthodontic, and medical services (to include durable medical equipment (DME), shift nursing, home health, elective medical/surgical outpatient, as well as inpatient services).
   a) Handles all phone and/or face-to-face beneficiary appeal hearings associated with these requests.
2. Provides operational assistance to pharmacy providers and inpatient/outpatient providers (to include physicians, DME, dental, home health, lab, and hospital providers) through outreach and communication, provider inquiry, and claims exceptions processing.
3. Manages the pharmacy benefit through utilization management including the Preferred Drug List, prior authorization, drug use review, and specialty pharmacy.
4. Reviews all inpatient and outpatient 180-day exception requests along with handling provider appeal hearings associated with these requests.
5. Serves as liaison with the FFS Delivery System Subcommittee.
6. Provides assistance to MA enrolled beneficiaries concerning their benefits.
7. Provides enrollment assistance to all providers wishing to enroll with MA for both the FFS and managed care delivery systems.
8. Provides case management services to beneficiaries with complex medical needs and catastrophic events.
9. Assists individuals in need of one-on-one support arrange for a registered nurse.

The BFFSP is organized into five divisions: Division of Medical Review, Division of Operations, Division of Pharmacy, Division of Provider Enrollment, and Division of Intense Medical Case Management.

Bureau of Managed Care Operations (BMCO):

The BMCO is responsible for the administration and oversight of the mandatory managed care programs that provide MA physical health benefits to beneficiaries in Pennsylvania. The BMCO also oversees the work of the Enrollment Assistance Program and the provision of Medical Assistance Transportation Program (MATP) services for HealthChoices and the commonwealth. The BMCO is divided into four divisions: Division of Monitoring and Compliance, Division of Quality and Special Needs Coordination, Division of Program Initiatives, Contract Management, and Communications, and Division of Medical Assistance Transportation.

1. The Division of Monitoring and Compliance monitors the HealthChoices agreements to ensure the PH-MCOs are compliant with program requirements, works with the PH-MCOs to implement program changes, responds to MA
beneficiary and provider concerns, and develops corrective action plans. This division also monitors the Enrollment Assistance Program contract.

2. The Division of Quality and Special Needs Coordination collects and reports on PH-MCO’s quality performance data to ensure compliance with contract standards and coordination of services for all MA beneficiaries. This division is the liaison with the OMAP Chief Medical Officer for special projects, joint initiatives and clinical guidance, and also identifies and coordinates with federal, state, and local agencies to provide services to special needs populations.

3. The Division of Program Initiatives, Contract Management, and Communications manages the procurement process for BMCO and manages development of the PH-MCO grant agreements, agreement amendments, and renewals. This division develops concept documents and reports associated with managed care and other operational areas of the MA program and coordinates publication of documents related to managed care.

4. The Division of Medical Assistance Transportation manages and oversees the various county contracts for the MATP program, as well as managing the Philadelphia broker-model.

Bureau of Fiscal Management (BFM):

The BFM is responsible for the administration and oversight of fiscal operations for both FFS and PH-MCO delivery systems. The BFM is organized into five divisions: Division of HealthChoices Rates, Division of Financial Analysis and Reporting, Division of Special Payments, Division of Hospital and Outpatient Rate Setting, and Division of Budget and Contracts.

Bureau of Policy, Analysis and Planning (BPAP):

The BPAP is responsible for the policy and program development for all inpatient, outpatient, and ancillary MA services in both the FFS and managed care delivery systems, as well as managing the functions of planning, analysis, and budgeting for the OMAP. The BPAP is divided into two divisions: Division of Planning, Evaluation and Budget Analysis and Division of Regulatory and Program Development.

a. History of the HealthChoices Program

HealthChoices is Pennsylvania’s physical and behavioral health mandatory risk-based managed care program. The HealthChoices physical health program was implemented using a zone phase-in beginning in 1997, became mandatory statewide as of March 1, 2013, and provides services to over 2.2 million members in 67 counties. Members not eligible for HealthChoices receive services through a FFS program. Currently, eight PH-MCOs participate in the HealthChoices program. The map below displays the current HealthChoices zones.
The **Southeast Zone** includes five counties and became operational in 1997. DHS provides physical health services in the Southeast Zone through grant agreements with Aetna Better Health, Health Partners Plans, Keystone First, and UnitedHealthcare Community Plan of Pennsylvania. As of August 2016, HealthChoices serves approximately 808,494 members in the Southeast zone.

The **Southwest Zone originally** included 10 counties that became operational in 1999 and expanded to four additional counties on July 1, 2012. DHS has grant agreements with four PH-MCOs to provide physical health services in the Southwest Zone: Aetna Better Health, Gateway Health, UnitedHealthcare Community Plan of Pennsylvania, and UPMC for You, Inc. As of August 2016, HealthChoices serves approximately 466,581 members in the Southwest Zone.

The **Lehigh/Capital Zone originally** included 10 counties that became operational in 2001 and expanded to three additional counties on July 1, 2012. DHS has grant agreements with five PH-MCOs to provide services to beneficiaries in the Lehigh/Capital Zone: Aetna Better Health, AmeriHealth Caritas Pennsylvania, Gateway Health, UnitedHealthcare Community Plan of Pennsylvania, and UPMC for You, Inc. As of August 2016, HealthChoices serves approximately 476,639 members in the Lehigh/Capital Zone.
HealthChoices expanded to the **New West Zone** on October 1, 2012. DHS has grant agreements with four PH-MCOs to provide services to beneficiaries in the New West Zone: AmeriHealth Caritas Pennsylvania, Aetna Better Health, Gateway Health, and UPMC for You, Inc. As of August 2016, HealthChoices serves approximately 160,776 members in the New West Zone.

HealthChoices expanded to the **New East Zone** on March 1, 2013. DHS has grant agreements with three PH-MCOs to provide services to beneficiaries in the New East Zone: AmeriHealth NE, Aetna Better Health, and Geisinger Health Plan. As of August 2016, HealthChoices serves approximately 305,831 members in the New East Zone.

HealthChoices PH-MCOs provide a comprehensive package of services that must include, at a minimum, the current Pennsylvania Medicaid benefits. Each PH-MCO provides some benefits not available through the Medicaid fee-for-service program, i.e., nurse advice lines, targeted case and special needs management, eyeglasses, and gym memberships. All PH-MCOs must ensure that their provider networks are compliant with federal and state regulations and ensure access to care for the members served.

PH-MCOs are not responsible for behavioral health services and/or drug and alcohol services; BH-MCOs provide these services. DHS’ OMHSAS manages the behavioral health component. Although PH-MCOs are not responsible for behavioral health services, they are contractually responsible for coordinating with BH-MCOs to ensure beneficiaries have access to comprehensive care.
b. Managed Care Goals, Objectives, and Overview

Within OMAP, BMCO is responsible for the administration and oversight of the HealthChoices program, including monitoring the managed care contracts to ensure that the PH-MCOs are meeting program requirements and performance targets. There are three key areas within BMCO responsible for the oversight of most activities identified in this Pennsylvania Quality Strategy for the physical health component:

1. The Division of Quality and Special Needs Coordination (DQSNC) is responsible for the overall quality program and PH-MCO performance.
2. The Division of Monitoring and Compliance (DMC) is responsible for monitoring and enforcing PH-MCO compliance with their agreements to support program performance.
3. The Bureau of Financial Management (BFM) supports DQSNC and DMC to review and advise on the PH-MCO solvency and provides financial support to the P4P programs under HealthChoices.

In addition, BMCO staff works closely with the OCQI that is under the deputy secretary for OMAP. This area has staff that includes the OMAP chief medical officer and the
OMAP chief dental director. Staff in this area also have the lead for the Health Information Technology (HIT) efforts for the commonwealth.

As previously mentioned, HealthChoices has been operational for over 19 years and became a statewide mandatory managed care program in 2013. Since HealthChoices is now the predominant delivery system for Medicaid services, it is imperative that OMAP ensures that the quality of the services, the quality of access to care, and the quality of the performance of our PH-MCOs is at the highest levels achievable by the program participants. In order to effectively manage and focus on important goals for the program, OMAP has implemented an approach to better align services, outcomes, and to provide an opportunity to share best practices through the implementation of Value-Based Purchasing (VBP).

OMAP, through collaboration with the HealthChoices PH-MCOs, created and implemented the VBP strategic approach to drive resource alignment for performance improvement to ensure the most value and highest quality services. Many of OMAP’s oversight efforts are now better designed to achieve specific outcomes.

The PH-MCOs are key partners with OMAP in the overall success of VBP. Through this collaborative approach, OMAP continuously monitors performance. Initially, all PH-MCOs had key initiatives focused on the two goals identified below. Through scheduled quarterly discussions with each PH-MCO, there is an opportunity to discuss the progress being made and the effectiveness of approaches in achieving the VBP goals. There is also an opportunity to share best practices so others can achieve greater success and chances to discuss lessons learned and what did not work as well to drive program outcomes. A more in-depth summary of the VBP goals and outcomes to date are provided later in this document.

The two primary goals initially targeted by VBP were:

1. Improved access to pediatric dental services (target goal set by CMS to increase the proportion of children ages 1-20 that receive a preventive dental service by 10 percentage points over a five-year period).
2. Reduce unnecessary hospitalizations (a reduction in preventable admissions/readmissions by one percentage point over time).

In the HealthChoices agreement amendment year of 2017, OMAP and BMCO will drive the VBP initiative to its next iteration. This will move HealthChoices toward the overarching goals of improved quality and ensuring that PH-MCOs are paying for the highest quality of care. To achieve this, the agreements mandate that the MCOs must enter into arrangements with providers that incorporate VBP strategies such as: provider P4P, patient-centered medical homes, shared savings contractual arrangements, bundled or global payment arrangements, and full risk or Accountable Care Organization payment arrangements. In each successive year of their agreements, the MCOs must apply an increasing percentage of their medical/maternity capitation to these strategies. By implementing this initiative, OMAP is aligning the
HealthChoices program with the growing VBP movement taking place in the national health care environment in both the public and private sectors. The PH-MCO must enter into arrangements with providers that incorporate VBP strategies such as gain sharing contracts, risk contracts, episodes of care payments, bundled payments, and contracting with Centers of Excellence (COE) and Accountable Care Organizations. Goals for VBP strategies are percentages of the PH-MCO’s expenditure of the medical portion of the capitation and maternity revenue received from DHS. The PH-MCO must achieve the following percentages of VBP:

a. Calendar year 2017 – 7.5 percent of the medical portion of the capitation and maternity care revenue must be expended through VBP strategies.

b. Calendar year 2018 – 15 percent of the medical portion of the capitation and maternity care revenue rate must be expended through VBP strategies.

c. Calendar year 2019 – 30 percent of the medical portion of the capitation and maternity care revenue rate must be expended through VBP strategies.

Compliance with these goals will be measured through reporting requirements. By January 1 of each calendar year, the PH-MCO must submit an informational report to DHS that outlines its plan for compliance in that calendar year. By the last work day of every quarter, the PH-MCO must submit a progress report. By June 30 of the subsequent calendar year, the PH-MCO must submit a report on accomplishments the prior year. This annual report must include a listing of the value based purchasing arrangements by provider; and an explanation of each arrangement; and the dollar amount spent for medical services provided during the previous year through these arrangements.

c. Development and Review of the Quality Strategy

The Pennsylvania Quality Strategy document aligns with the requirements of 42 CFR § 438.204. In August 2014, an internal DHS team began collaborative discussions on the development of its overall Quality Strategy. Upon completion of the draft strategy document, a two-week internal review process was undertaken. On October 16, 2014, the proposed draft Quality Strategy was shared with upper management staff within DHS for final review. The document began the public comment review period on November 22, 2014. The Quality Strategy was sent to the Chairs of the MAAC and its Subcommittees and was posted on the DHS web site for public review and comment. Lastly, DHS sought public comment through posting a Public Notice. The public was allotted 30 days to review and comment. To provide an opportunity for other stakeholders to offer their feedback on the Quality Strategy, DHS will publish the draft Quality Strategy on its web site as it is updated. See pages 7-9 for further details.
2. Assessment

a. Quality and Appropriateness of Care

Under the HealthChoices program, the PH-MCOs are held to standards to ensure that all members receive quality and appropriate care. For this to be assessed, there are requirements built into the HealthChoices agreement and oversight of these requirements by staff in OMAP that occur on a regular basis to identify and resolve discrepancies and/or deficiencies in a timely manner. Following is a description of the identification of individual member demographics (including members with special needs) that occurs at the time of enrollment.

At the point of entry into the HealthChoices program, the enrollment assistance contractor will assist the member with selection of a PH-MCO. In addition, they may gather information on members that includes a wide range of indicators, including pregnancy and if a special need is identified. (The staff at the county assistance offices (CAO) handles the determination of eligibility for MA benefits.) Under HealthChoices, the definition of special needs is as follows:

**Special Needs** — The circumstances for which a member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional, or behavioral conditions.

All pertinent information gathered by the enrollment assistance contractor at the time of enrollment is sent to the PH-MCO the member has chosen. The PH-MCO also gathers other data on new members by conducting new member outreach calls. Member education has been one of the basic tenets of the HealthChoices program. PH-MCOs have developed and implemented effective member education and outreach programs that include health education programs focusing on the leading causes of hospitalization and emergency room use, and health initiatives that target members with special needs, including those diagnosed with: HIV/AIDS, intellectual disabilities, chronic diseases, etc. PH-MCOs are also required to establish and maintain a Health Education Advisory Committee that includes beneficiaries and providers of the community to advise on the health education needs of HealthChoices members. Representation on this committee must include, but not be limited to, women, minorities, people with expertise on the medical needs of children with special needs, and physical health, behavioral health, and dental health providers.
b. Procedures for Race, Ethnicity, Primary Language, and Data Collection

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

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

Several of the PH-MCOs have achieved the NCQA Multicultural Health Care Distinction and have continued to maintain this distinction.

In addition, OMAP requests the PH-MCOs to submit member level Healthcare Effectiveness Data Information Set (HEDIS®) data files as part of the overall HEDIS® audit process. OMAP utilizes this data to evaluate potential PH-MCO disparities within the specific HEDIS® measures that are reported and also may review the information in comparison across HealthChoices zones. Observations from the member-level data are identified and used for discussions with the PH-MCOs during the Quarterly Quality Review Meetings (QQRMs). When presenting the member-level data, there need to be certain footnotes indicated for results that may not be consistent across all measures, i.e., rates produced from small denominators can produce rates with greater variability or greater margin of error.

c. Community-Based Care Management (CBCM)

For 2015, OMAP tasked each PH-MCO to implement programs that focus on care management that is community-based. Monies have been allocated for each PH-MCO for CBCM. All PH-MCOs are to submit proposals that will outline their plan to ensure that they are meeting their members in the community for care management versus continuing to model their care management programs using a predominantly telephonic approach that has been the norm for many years. While telephonic outreach may continue to be useful for certain types of outreach, the CBCM requires face-to-face encounters with members who may be in need of more focused outreach. Each PH-MCO must submit its proposal(s) for CBCM and will be reviewed and approved by OMAP. The requirements for PH-MCOs to submit CBCM proposals on a yearly basis
continues. To date, the PH-MCOs have used the opportunity of using CBCM monies to implement innovative programs to provide face-to-face, community care management opportunities for its members. Examples of innovative programs include, co-location opportunities at Federally Qualified Health Centers (FQHCs) for PCP and dental services to be provided at the same visit; opportunities for enlistment of Community Health Workers (CHWs) to connect with members in the community; and the utilization of Public Health Dental Hygienist Practitioners (PHDHPs). The requirement for PH-MCOs to develop new programs and provide updates to current programs continues as a requirement under the HealthChoices agreement into 2017. BMCO, under the DQSNC, requires regular reporting by the PH-MCOs on the progress of the development of CBCMs through its operational reporting and through discussions with each individual PH-MCO at the regularly scheduled QQRMs. OMAP will report on a status of this effort with a future update to the Quality Strategy.

d. National Performance Measures

OMAP and BMCO have shared goals for this vision for delivering the highest quality services to HealthChoices members. HealthChoices provides quality medical care and timely access to all appropriate covered physical health services, whether the services are delivered on an inpatient or outpatient basis. The three goals of the HealthChoices program include:

**Goal 1: To improve access to health care services for MA beneficiaries** - HealthChoices members have access to a comprehensive provider network in each HealthChoices Zone. PH-MCOs provide members with education and outreach programs that may include health education programs focusing on the leading causes of hospitalization and emergency room use. Members also have access to a member hotline 24 hours a day, 7 days a week. Members are connected with a medical home to coordinate and manage services and assist in referrals and system navigation. Access to health care services is assessed by monitoring network requirements, network changes, HEDIS® access to care measures, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

**Goal 2: To improve the quality of health care available to MA beneficiaries** - Quality of health care is assessed by measuring and monitoring HEDIS®, CAHPS, and additional Pennsylvania performance measures (PAPM). Additionally, OMAP implemented a P4P program for managed care and providers in 2005 to encourage continuous quality by aligning incentive payments with high quality health care for all members. HealthChoices performance has improved since implementation. Improved plan performance ultimately benefits members’ quality of life, saves lives, and reduces inappropriate health care costs.

Performance-based contracting in the HealthChoices program is based on HEDIS® rates and rates for select PAPM. These measures are in four broad categories: chronic care, preventive care and early detection, prenatal care, and utilization.
OMAP is building on the success of the program to implement components of a VBP model. VBP is more than P4P, and requires active, ongoing purchaser oversight. OMAP will continue its two-pronged PH-MCO approach with ensuring there is equal merit given to contract monitoring that ensures continued access in the program that provides for sound provider networks and continued monitoring of quality outcomes that measure not only the value but the value of the services the commonwealth has purchased.

**Goal 3: To stabilize Pennsylvania's MA spending** – OMAP contracts with PH-MCOs on a full-risk capitated basis to provide comprehensive services through an efficient, cost effective system of care. OMAP has concentrated on reducing inappropriate emergency room utilization and preventable admissions/readmissions.

A comprehensive set of public reports that demonstrates how these national measures are publicly reported can be found at the following web site:


e. PH-MCO P4P Program

OMAP requires that the PH-MCOs report on all HEDIS® measures, excluding measures requiring a mental health benefit. For the 2017 PH-MCO P4P program, DHS selected eight HEDIS® 2017 and one 2011 PAPM as quality indicators (representing CY 2016 data) for the MCO P4P program. The nine quality indicators are:

**HEDIS®:**

1. Adolescent Well-Care Visits  
2. Annual Dental Visit (Ages 2 – 20 years)  
3. Comprehensive Diabetes Care: HbA1c Poor Control  
4. Controlling High Blood Pressure  
5. Frequency of Ongoing Prenatal Care  
6. Prenatal Care in the First Trimester  
7. Postpartum Care  
8. Well-Child Visits in the First 15 Months of Life, 6 or more  
9. Medication Management for People with Asthma 75%

**PAPM:**

1. Reducing Potentially Preventable Readmissions

OMAP chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices program as well as the potential to improve health care for a broad base of the HealthChoices population. The P4P payout structure is based upon the PH-MCO meeting designated benchmarks for the measures mentioned above. In addition to the benchmark payouts, there is an opportunity for the PH-MCOs to also earn dollars for incremental improvement performance. There is an
offset penalty for performance that does not meet the benchmarks that have been established for the P4P program.

**f. Provider P4P Program**

OMAP implemented a Provider P4P program in 2007 which aligns with the PH-MCO P4P program. The Provider P4P quality measures are the same as the PH-MCO P4P quality measures listed above. In addition to these measures, the PH-MCOs are encouraged to incent providers who electronically extract and submit the data for the quality measures. The PH-MCOs are required to incent providers with specific earmarked dollars. The PH-MCOs must submit to DHS annually their proposed Provider P4P program for review and approval. The PH-MCOs also are required to submit an analysis of their Provider P4P program annually to BMCO.

**g. Obstetrical Needs Assessment Form (ONAF)**

The ONAF is used by the PH-MCOs as the initial notification of pregnancy, as well as ongoing maternity assessment for members from their providers. Providers are encouraged to submit the ONAF to the PH-MCOs which allows enrollment of members in the appropriate maternity program as early as possible and provides an opportunity for the member and provider to receive additional support through the member’s PH-MCO. OMAP uses the ONAF as a method to capture OB related HEDIS® and P4P quality measures. The ONAF is also used to effectively and smoothly transition pregnant women from PH-MCO to PH-MCO. In addition, as part of the Adult Medicaid Quality Measures Grant, the PH-MCOs have been encouraged to use grant funds for the electronic extraction of the ONAF and continue to work with Optum Technology to advance a uniform electronic data solution.

**h. Adult and Children’s Core Set of Measures**

OMAP requires that the PH-MCOs report to DHS on the Adult and Children’s Core Set of quality measures. This information is included in Appendix A.

**i. Monitoring and Compliance**

BMCO continues to meet regularly with PH-MCOs to discuss operations issues and to apprise the PH-MCOs of administrative changes and updates that may have an impact on service delivery. In addition, in 2014 a quarterly quality component was added to ensure that there are devoted meetings with each individual MCO – QQRM – to discuss key quality indicators, best practices, and areas for improvements. The basis of these meetings is an open, creative, collaborative dialogue with OMAP and the PH-MCOs with an emphasis on quality outcomes and the established VBP goals and targets. The QQRM is an opportunity to:

1. Review the PH-MCO performance against stated goals.
2. Investigate causes of missed goals and targets.
3. Implement corrective action steps for plans that missed targets.
4. Establish new targets.

j. HealthChoices Operations Monitoring: Division of Monitoring and Compliance (DMC)

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

k. HealthChoices Division of Quality and Special Needs Coordination

The Department’s Division of Quality and Special Needs Coordination is located within the OMAP’s BMCO. This division is dedicated to the complete and seamless integration and coordination of physical and behavioral health services to meet the individualized needs of PH-MCO members, oversee the PH-MCO grievance and appeals process and DHS fair hearings, oversee PH-MCO Quality/Utilization Management activities, oversee EQR activities, and oversee other PH-MCO quality data and reporting activities. DQSNC staff has been an active participant in various committees and work groups that have resulted in the provision of necessary services. DQSNC also produces several reports that reflect quality outcomes and beneficiary satisfaction with the HealthChoices program. These are publicly posted on the DHS web site.

DQSNC staff within the Special Needs Unit work closely with the PH-MCOs to ensure those Medicaid members who are receiving home shift care services and who will “age-out” of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are transitioned effectively to appropriate home and community-based waiver services upon reaching the age of 21. In addition, DQSNC staff is committed to ensuring a beneficiary centered focus by proactively participating with stakeholders by continued participation in stakeholder activities – workgroups, meetings, and community presentations.

In 2014, DQSNC began holding QQRMs with each PH-MCO to discuss key goals in a direct forum that would engage and address issues in various data sources, such as HEDIS®, that are reported to DHS. The main topics of discussion centered on the CMS
Oral Health Initiative and Improving Access to Pediatric Preventive Dental Care. Each PH-MCO would:

1. Improve access to pediatric dental services (target goal set by CMS to increase the proportion of children ages 1-20 that receive a preventive dental service by 10 percentage points over a five-year period). This goal is tied to the CMS Oral Health Initiative that requires Pennsylvania Medicaid to realize a ten percentage point improvement in its dental services rate that is calculated through encounters submitted by the PH-MCOs for the CMS-416 reporting by the end of federal fiscal year 2015.

As an incentive, through the MCO P4P program, OMAP has doubled the payout for the HEDIS® Annual Dental Visit Measure. Each PH-MCO has the ability to earn a double payout for meeting certain benchmarks for this measure. This additional payout continues for 2016. Also, for the 2016 Provider P4P program, OMAP requires that for the Annual Dental Visit measure, all PH-MCOs build into their provider incentive program some type of incentive for the dentist.

Another key area of focus for discussion with the PH-MCOs at the QQRMs is what initiatives PH-MCOs are doing to reduce potentially preventable admissions and readmission.

For 2016, through the MCO P4P program, OMAP established a goal of 8.5 percent for PH-MCOs to reach in order to receive a benchmark payout. Since the readmission measure is not a HEDIS® measure, there is no national benchmark so Pennsylvania decided to set a target for PH-MCOs to receive a payout in hopes this will incent them to improve their rates. In addition, for 2016, the incentive payout for improvement on the readmission measure will continue.

For 2015, DQSNC staff were assigned the management and reporting to CMS of the Adult Core Set and Children’s Health Insurance Program Reauthorization Act (CHIPRA) measures through the newly designed MACPRO system.

In 2015, DHS began a new Performance Improvement Project (PIP) cycle. DHS has chosen the two topics mentioned above as PIPs that all PH-MCOs must conduct over the new PIP cycle. They are: Improve Access to Pediatric Preventive Dental Care and Reduce Potentially Preventable Admissions and Readmissions. The DHS EQR contractor will work with OMAP to track these PIPs as they conduct their validation and analysis of the PH-MCO PIP proposals and interventions.

For 2016, OMAP continues to support the PH-MCOs to further develop CBCM programs that are focused on reducing preventable admissions, readmissions, non-emergent visits to the emergency department (ED), enhancing behavioral and physical health coordination of services, target providers/organizations that serve a large volume of complex MA beneficiaries including high risk pregnant women and increasing access to pediatric dental preventive and restorative services. CBCM will continue for 2017 and
DHS will continue to track the outcomes of the various initiatives. For 2016, OMAP, in partnership with OMHSAS, began another incentive program that fosters collaboration between the PH-MCOs and county/BH-MCOs. DHS will provide financial incentives to the PH-MCOs and the BH-MCOs for the Integrated Care Plan (ICP) program. DHS will incentivize the PH-MCOs based on shared PH/BH-MCO performance measures. DHS expects the ICP program to improve the quality of health care and reduce MA expenditures through enhanced coordination of care between the PH-MCOs, BH-MCOs, and providers for members with Serious Persistent Mental Illness (SPMI). For 2017, the ICP program will continue and DHS will track the coordination efforts and outcomes that occur as a result of the shared efforts for these members.

For 2017, DHS may revise the Provider P4P program to standardize the dollar incentive amounts for certain mandatory measures paid by the PH-MCOs to its providers within the program. This will allow for consistency in payouts to certain providers who may participate with multiple PH-MCOs in the various zones of the HealthChoices program.

For future years, DHS is planning to implement a patient-centered medical home (PCMH) model within the HealthChoices program. As the model is further defined, information may be shared through updates to the 1915(b) waiver.

I. Monitoring Standards and SMART System

On an ongoing basis, DHS staff members who comprise the PH-MCO contract management teams are responsible for monitoring certain agreement standards for each PH-MCO. Program monitors and supporting team members use an electronic tool known as SMART (Systemic Monitoring and Access Retrieval Technology) to conduct this monitoring using approximately 330 performance standards. SMART is a menu-driven database that stores documentation of agreement compliance monitoring results. Depending upon the nature and priority of the standard, the contract manager reviews the standards on a monthly, quarterly, semi-annual, or annual basis. The reviewer will assign a rating of “compliant” or “non-compliant” for each of these standards. For non-compliant standards, the contract manager and their program monitors may discuss with the PH-MCO a solution to address the agreement non-compliance or area needing improvement. The PH-MCO then has an opportunity to implement a solution to the non-compliant issue. If the deficiency or non-compliant issue cannot be resolved via this process, the PH-MCO may be required to present a CAP. The DHS contract manager tracks and monitors the PH-MCO’s adherence to this CAP until the problem is resolved.

m. Clinical Guidelines

OMAP requires that each of the PH-MCOs’ Quality Management and Utilization Management Programs include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services. The programs must include professionally developed practice guidelines of care written in measurable and accepted professional formats, based on scientific evidence and applicable to providers for the delivery of certain aspects of
health care. Practice guidelines must address the full range of health care needs of the populations served by the PH-MCO, and must be reviewed at least annually and approved by the PH-MCO’s internal Quality Improvement Committee.

n. External Quality Review Organization (EQRO)

DHS contracts with an External Quality Review Organization (EQRO), IPRO, to perform the mandated standard external quality review activities that are required as part of 42 CFR § 438, Subpart E. These activities include: Performance of an annual EQR of each contracting MCO or PIHP, Validation of PIPs, Validation of MCO Performance Measures, Reviews of MCO Compliance with Monitoring Standards (previous 3-year period), Validation of Encounter Data, Validation of Beneficiary/Provider Surveys, and Validation of other Pennsylvania Performance Measures (as designated by DHS). The results of these EQRO activities will contribute to updates for the Pennsylvania Quality Strategy.

3. State Standards

a. Access Standards

A key component to achieving OMAP’s goals is to provide data that is accurate and clearly reflects the performance of the PH-MCOs in managing the delivery of health care to their HealthChoices members. These data elements are necessary to measure performance against program standards. Currently, OMAP/BMCO requires annual, biannual, quarterly, and monthly reports for a number of performance metric results (refer to Appendix B for a list of the required reports). The PH-MCOs submit the results using state-specific definitions and required timeframes for calculation and reporting.

b. Performance Measures and P4P

OMAP’s P4P program for HealthChoices was implemented in July 2005. The P4P program aligns MA payments with quality, access, and efficiency objectives by providing financial incentives to PH-MCOs that meet quality goals. OMAP allocates incentive dollars to each performance measure and PH-MCOs earn incentives by meeting benchmark performance and improvement targets. This P4P model incentivizes PH-MCOs to perform well against a pre-established benchmark and to improve their performance over previous years. The model also discourages poor performance by including an offset component that reduces a PH-MCO’s total payout when it performs below the HEDIS® 50th percentile benchmark for any measure. Additionally, each PH-MCO is given funding for implementing a Provider P4P program that is aligned with the PH-MCO P4P program.

OMAP’s Provider P4P program was implemented in 2007. The Provider P4P program aligns with the PH-MCO P4P program focusing on improvements in the quality of or access to health care services for members. In addition, the PH-MCOs are encouraged to incent providers who electronically extract and submit the data for the quality
measures. OMAP has earmarked specific dollars for which the PH-MCOs are required to incent their providers. The PH-MCO is required to send all of the Provider P4P allocation payments to their specified provider network.

c. Performance Improvement Projects

These EQR-mandated projects address a range of priority issues for the HealthChoices population. For the new PIP cycle that runs from 2016 through 2018, the PH-MCOs are required to prepare PIPs for the following two key quality areas:

1. Reducing potentially avoidable admissions and readmissions.
2. Increase access to pediatric preventive dental services.

OMAP made the decision to incorporate these two key areas into its new PIP cycle since they have been areas of key focus through the QQRMs for the last two years and the groundwork has already been developed for the PH-MCOs to take their programs and interventions to the next level. In addition, for both of these topics there is a tie-in to the P4P programs and the preventive dental incorporates the continued focus of CMS on the Oral Health Initiative, which was extended through 2018.

d. State Standards

To provide appropriate access to care for HealthChoices members, all standards for access to care, structure and operations, and quality measurement and improvement found in 42 CFR § 438, Subpart D, are referenced throughout the Quality Strategy document and were incorporated in the PH-MCO contracts, which is in accordance with federal regulations. Appendix C refers to Section III of the Quality Strategy Toolkit Checklist and lists these state standards.

e. Mechanisms

As required by 42 CFR § 438.204(b)(3), BMCO regularly monitors and evaluates PH-MCO compliance with the contract standards. Please see the Quality Strategy Toolkit Checklist in Appendix C for a listing of standards and the related contract language and standards. BMCO requires PH-MCOs to maintain systems that document implementation of the written quality management program description. The PH-MCO must also develop and implement monitoring mechanisms that are consistent with the Quality Strategy, such as:

1. An annual program description that documents the PH-MCO’s monitoring strategy across all services, all treatment modalities, and all sub-populations.
2. An annual program evaluation that details all quality management program activities including, but not limited to, studies and activities undertaken, including the rationale, methodology and results, subsequent improvement actions, and aggregate clinical and financial analysis of Encounter, HEDIS®, CAHPS, Pennsylvania Performance Measures, and other data requested by DHS.
3. A work plan and timetable for the coming year which clearly identifies target
dates for implementation and completion of all phases of all quality management
activities, including, but not limited to:
   a. Data collection and analysis.
   b. Evaluation and reporting of findings.
   c. Implementation of improvement actions where applicable.
   d. Individual accountability for each activity.
   e. Reporting.

f. Member Satisfaction Survey

BMCO contractually requires the PH-MCOs to conduct a member satisfaction survey on
at least an annual basis. This includes the collection of annual member satisfaction data
through application of the CAHPS instrument. The PH-MCOs contract with independent
CAHPS survey organizations accredited by the NCQA to administer the survey. The
CAHPS survey organizations administer the survey annually to a statistically valid
random sample of clients enrolled in the HealthChoices program at the time of the
survey. The standardized survey tool includes questions designed to assess specific
dimensions of client satisfaction with providers, services, delivery, and quality, including
but not limited to:

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

g. Provider Satisfaction Survey

BMCO requires the PH-MCOs to conduct annual provider satisfaction surveys. Provider
responses to the survey questions assist the PH-MCOs in identifying areas for
improvement and developing action plans. Providers that participate in the survey
include PCPs, specialists, dental providers, hospitals, and providers of ancillary
services.

h. Grievance and Appeals Logs and Reports

For each of the PH-MCOs, BMCO staff reviews grievance and appeals logs and reports
on a regular quarterly basis. The DQSNC Grievance and Appeals unit is responsible for
reviewing these reports and provides regular audits of the PH-MCO grievance and
appeals processes. The findings that are developed are shared directly with the PH-
MCO externally and are also shared with the DMC contract managers internally. In
addition, data from the reports are used in the PH-MCO Comparative Reporting and
other types of public reports.

i. HEDIS® and Other Performance Measure Results

BMCO uses three formal sources of performance data: HEDIS®, CAHPS, and
Pennsylvania Performance Measures (PPM). HEDIS® is the most widely used set of
clinical performance measures in the managed care industry. BMCO requires that PH-MCOs submit performance data to provide useful and timely performance comparison information to plans, beneficiaries, and other stakeholders through annual Performance Trending Reports. BMCO compares plan results to HEDIS® and CAHPS national benchmarks that NCQA calculates using rates reported nationally by Medicaid MCOs. This information is used by BMCO to develop HealthChoices zone-specific Beneficiary Guides that are updated on an annual basis and used by the enrollment assistance contractor to assist members in their PH-MCO selection.

j. Consumer Assessment of Healthcare Providers and Systems

The CAHPS surveys ask beneficiaries and patients to report on and evaluate their experiences with health care. The Agency for Healthcare Research and Quality (AHRQ) provides CAHPS surveys that cover topics that are important to beneficiaries and focus on aspects of quality that beneficiaries are best qualified to assess, such as the communication skills of providers and ease of access to health care services. BMCO requires that PH-MCOs:

1. Conduct both an adult and child CAHPS survey using the current version of the CAHPS survey tool.
2. Include all Medicaid core questions in both surveys.
3. Customize the survey for Pennsylvania by adding the following three dental questions to both the adult and child CAHPS surveys:
   a. In the last six months, did you get care from a dentist’s office or dental clinic?
   b. In the last six months, how many times did you go to a dentist's office or dental clinic for care for yourself?
   c. We want to know your rating of your dental care from all dentists and other dental providers in the last six months. How would you rate your dental care (on a scale of 1 to 10)?
4. Submit validated CAHPS results annually on June 15 to BMCO.

k. Health Information Technology

Pennsylvania has positioned itself as a leader among state MA programs in the use of electronic health care information to improve the quality and cost-effectiveness of service delivery for MA beneficiaries. DHS understands the impact that HIT can have on patient health outcomes and improving efficiency and continuity of care delivery. DHS also realizes that real-time patient-level clinical data is necessary to advance its Quality Strategy and that this data can only be obtained and effectively utilized when providers adopt and implement Electronic Health Records (EHRs) and electronically exchange health information. Hospitals, physicians, and other health care professionals must become meaningful users of EHR technology, which includes measuring and improving patient outcomes and exchanging health information with DHS, stakeholders, and each other. The MA EHR Incentive Program supports the adoption, implementation and meaningful use of federally certified EHRs and is an important component of DHS’ quality and HIT strategy.
Along with the MA EHR Incentive Program, supporting electronic health information exchange is another key component of DHS’ quality and HIT strategy. The Pennsylvania eHealth Partnership Program (Program) is now a part of DHS per state law. The purpose of the Program is to improve health care delivery and health care outcomes in Pennsylvania by enabling the secure exchange of health information (HIE). OMAP collaborates with the Program on a number of initiatives, all of which are aimed at promoting HIE among providers. The collaboration between the two offices within DHS facilitates the sharing of health care information across authorized users in an accessible and secure manner and improves the access to electronic health information for all of Pennsylvania’s health care providers, payers and patients. OMAP’s HIT vision recognizes that electronic exchange of health information is a key component in DHS’ efforts to measure clinical quality measures and work with providers to improve outcomes.

The HIE model in the commonwealth is a statewide network of networks with an overarching governing entity to provide a thin layer of community shared services (CSS). These services enable secure, confidential information exchange from one organization to another to give providers relevant, timely patient data needed to make treatment and care decisions. The Program is working with HIEs, integrated delivery networks (IDNs) and other similar entities in the commonwealth to develop the CSS layer to provide interoperability between these organizations. The CSS layer supports the ability of health care participants to exchange information within and beyond Pennsylvania’s borders. The Program’s goals for the CSS layer are to:

1. Build capacity for exchanging health information.
2. Increase connectivity and the flow of patient information to improve quality and efficiency of care.

The CSS layer will also provide access to services that will be used and paid for by participating entities, allowing them to avoid replicating costs for functionality that all can benefit from. This includes but is not limited to:

1. Provider Directory services to locate providers across the commonwealth.
2. Patient Index services to help associate records for a given patient despite differences in various demographic identifiers in different systems.
3. Consent Registry allows patients to record a preference to not have data exchanged and allows participating organizations to identify and respect these preferences.
4. Record Locator Services to locate sources of patient records.
5. Public Health Gateway, which permits single communications channel for all transactions between private sector organizations and governmental entities (i.e. immunization registry, lab registry, cancer registry, etc.).

All organizations wishing to connect to the CSS must complete a certification process managed by the Program. Certification criteria are meant to ensure uniform
interpretation and implementation of legal, privacy, and security considerations across the network of networks. This includes adoption of shared policies such as a network privacy policy, user management policy, and monitor-audit-breach policy, and includes adoption of uniform documents such as a notice of privacy practices, business associate agreement, data use, and reciprocal support agreement. All certification criteria, shared policies, and shared forms were developed in cooperation with stakeholders from the organizations who will be required to adopt them. Underpinning the commonwealth’s HIE network strategy is a connection model described in Figure 1 below. This model identifies a number of organizations that have important roles in successfully establishing HIE services. These organizations need to collaborate in order to provide critical functions necessary to enable the Pennsylvania HIE infrastructure.

Figure 1: Commonwealth HIE Connection Model

The technology available to advance DHS’ Quality Strategy continues to change and improve. Federal requirements, e.g., meaningful use, are also continuing to change and to become more ambitious and challenging for providers to meet. DHS must continually assess and update its HIT quality strategy to take advantage of new innovations and to continue to advance its goals. Future initiatives include:
1. DHS is looking for ways to leverage the various quality measurement and performance improvement initiatives across DHS and other departments and agencies. For example, OMAP currently collects HEDIS® measures from Medicaid managed care plans and many of these measures are included as part of the meaningful use criteria under the EHR Incentive Program. DHS is looking for ways to reduce provider burden by electronically collecting data through one process, which should be facilitated by the use of HL7 interfaces as part of using federally certified EHR systems to achieve meaningful use.

2. In addition to leveraging performance measure and quality data collection practices across DHS and other departments, DHS is also looking into solutions for collecting and exchanging this information. Current data warehouse configurations are not suited to collecting electronic clinical quality measures and instead focus on claims and administrative data. The DHS is looking at ways to efficiently and effectively collect this quality data in a way that allows for data analysis and using the data to improve care.

4. Improvements and Interventions

This section describes how, based on assessment activities, DHS will work to improve quality of care, and specifically, what processes and tools DHS will use to improve performance in meeting the Quality Strategy’s objectives. DHS will determine interventions for quality improvement based on review and analysis of baseline data, results of quality improvement activities and ongoing assessment of members' health care needs. The following is a description of the process DHS will use, along with a brief description of the various program components.

a. Community Based Care Management

Information on the PH-MCO CBCM process is outlined above at Section 2.c. of the OMAP portion of the Quality Strategy.

b. PH-BH Coordination – Integrated Care Program (ICP)

This program is a VBP program that focuses on integrating care for individuals living with a diagnosis of SMI. To receive the incentive money, the PH-MCO must collaborate with the HCBH Primary Contractor/BH-MCO on a sample of PH/BH HC members to develop a joint care plan, to notify each other on a hospital admission, and report care activities on a spreadsheet with a unique beneficiary identifier. These activities and the results of five performance measures when compared to the previous year’s results provide the amount of incentive payment based on the improvement demonstrated. The selected Offeror will update the measurement specifications and provide the results by PH-MCO and BH-MCO.
c. Patient-Centered Medical Home

The PCMH Advisory Council was established by Act 198 of 2014. The goal is to implement a statewide medical home model. The intent of the DHS is to integrate a model of care between PH and BH Managed Care Plans in which the goal would be to provide care that is comprehensive (children, youth, adults), coordinated, and patient-centered. It is anticipated that DHS will require performance improvement, effectiveness, and efficiency analyses. These projects will be defined by DHS and will be due at mutually agreed upon deadlines.

d. Opioid Use Disorder- Centers of Excellence (OUD-COE)

DHS will implement 45 OUD-COE in the HealthChoices Physical Health and Behavioral Health Programs throughout the commonwealth. This initiative will increase the capacity to care for those seeking treatment for OUD, as well as increase the overall quality of care. The PH-MCOs and BH-MCOs will be required to contract with all selected OUD-COE within the regions in which they operate. The MCO will work with each OUD-COE to coordinate care, collect aggregate quality measures, and develop a regional and statewide learning network. The MCO will work with the OUD-COE care management team to obtain written consent to share OUD related information that is compliant with state and federal laws and regulations. Once consent is obtained the PH-MCO will work collaboratively with the appropriate behavioral health MCO to coordinate comprehensive services.

e. Telephonic Psychiatric Consultation Services Program (TiPS)

DHS implemented, within the HealthChoices program, a statewide TiPS program. TiPS is a new program designed to increase the availability of peer-to-peer child psychiatry consultation teams to PCPs, medical specialists, and other prescribers of psychotropic medications for children insured by Pennsylvania’s MA programs. The program provides real time provider-to-provider or peer-to-peer resources to the PCPs and other providers who desire immediate consultative advice for children with behavioral health concerns, covered by MA, up to age 21. Phone inquiries are usually patient-specific, but can also be about any general question related to child psychiatry, behavioral health, or community resources. The PH-MCOs entered into subcontractual agreements with the three vendors who were selected to operate TiPS throughout the commonwealth.

5. Delivery System Reforms

In 2015, children in the Pennsylvania CHIP program with parental income less than 133 percent of the federal poverty level transitioned into the HealthChoices program.

As the above-mentioned reforms were implemented, all of the previously mentioned quality metrics were deployed to assure access to care, quality of care, and beneficiary satisfaction.
6. Conclusions and Opportunities

Staff in OMAP will take the lead on soliciting input on the Quality Strategy from a number of sources such as the MAAC and its subcommittees. As programmatic changes are implemented, OMAP will evaluate the effectiveness of the Quality Strategy and revise the strategy based upon analysis of the outcomes.

DHS will incorporate the annual EQR report in the development of the work plan, and DHS will solicit EQRO input. In addition, the work plan will reflect input from the DHS staff, the DQSNC Team and the DMC Team and may reflect feedback from other subcommittees, governmental agencies, providers, beneficiaries, and advocates. These sources help DHS to determine areas of focus for quality activities such as quality improvement measures, improvement projects and performance indicators.

As part of this review, DHS will evaluate the effectiveness of the Quality Strategy to determine whether potential changes to the Quality Strategy may be needed. Should the DMC or DQSNC determine the change is significant enough to require additional stakeholder input, these groups may recommend that DHS solicit additional feedback.

The DHS senior management team will review and revise the Quality Strategy before finalizing the strategy and submitting it to CMS. This team, with ultimate responsibility for approving and monitoring the Quality Strategy, may also solicit additional feedback and public input. Following DHS’ approval of the Quality Strategy, DHS will discuss any amendments or major revisions to the Quality Strategy with CMS.

The DHS will continue and expand as appropriate the work being done with the Pennsylvania Department of Health related to chronic disease, maternal and child health, and other innovative initiatives. Some of the areas of opportunity include asthma, diabetes, including self-management, chronic disease self-management, tobacco cessation, dental, children and youth with special health care needs, all payer claims database, prescription drug monitoring, and telehealth.

In summary, the HealthChoices Quality Strategy is a plan that will bring the HealthChoices program to the next level with a focus on quality and health outcomes, while still incorporating key components of contract compliance and other monitoring. This comprehensive plan will improve the delivery of quality care and services to HealthChoices members. The quality improvement infrastructure is in place to monitor the access and quality of care for those beneficiaries that will be new to the HealthChoices program because of health care reforms mentioned above. The Pennsylvania Quality Strategy provides a framework to communicate DHS’ goals and objectives to the PH-MCOs, BH-MCOs, CHIP contractors, CHC-MCOs and the ACAP Home and Community-Based Services (HCBS) providers and other stakeholders, while focusing on strategies that consider health care cost, quality, and timely access to care.
ii. Office of Mental Health and Substance Abuse Services (OMHSAS)

1. Introduction - History, General Information, and Managed Care Quality Program Objectives

a. General Information & History

OMHSAS’ Mission and Vision:

Every individual served by the mental health and substance abuse service system will have the opportunity for growth, recovery, and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family members and friends.

Pennsylvania MA beneficiaries have been enrolling in managed care plans since 1986 with the establishment of the HealthPASS pilot program in Philadelphia. The HealthChoices program, which was implemented in 1997, considerably expanded managed care. It also separated the delivery of physical health from behavioral health, with physical health provided through PH-MCOs and behavioral health provided through BH-MCOs. Behavioral health services include services for mental health and substance use disorders.

HealthChoices: Behavioral Health

The HealthChoices program for behavioral health care is managed by OMHSAS, which is located within DHS. The commonwealth has 67 counties that have been afforded the right of first opportunity to contract with DHS for the HealthChoices Behavioral Health (HCBH) Program. Forty-three counties have signed agreements using the right of first opportunity and have sub-contracted with a BH-MCO to manage the program. Twenty-four counties have elected not to participate in a direct agreement and as such, DHS holds agreements directly with two BH-MCOs to directly manage the programs for these counties. There are 34 agreements utilizing several different models that have been successfully operating in Pennsylvania. For economy of scale, numerous counties have come together to create oversight entities that coordinate the county contractors while proving an oversight function of the BH-MCOs. Only one BH-MCO provides behavioral health care in a given county.

Managed behavioral health care was phased in between 1997 and 2007 in the designated HealthChoices regions (Southeast in 1997, Southwest in 1999, Lehigh/Capital in 2001, Northeast in 2006, and North Central/State Option and North/Central County Option in 2007). In the North/Central State Option region, DHS has contracted directly with a BH-MCO to cover these 23 counties. There are five different BH-MCOs that operate in Pennsylvania: Community Behavioral Health (CBH), Community Care Behavioral Health Organization (CCBHO), PerformCare formerly known as Community Behavioral Health Network of Pennsylvania, Magellan Behavioral Health (MBH), and Value Behavioral Health of Pennsylvania (VBH-PA).
Starting in 2015, Pennsylvania expanded the Medicaid Managed Care (MMC) program and started to include children up to 21 and adults at or below 138 percent of the federal poverty level. The net increase of eligible individuals was 514,535 when December 2014 numbers are compared with December 2015 numbers, an increase of 21 percent. The HCBH chart detailing the HCBH Zones, county and the aligned BH-MCOs with the eligible numbers is below.

The HCBH program for behavioral health care has had a long history of stakeholder input at every level of the system since 1997. The initial 2014 Pennsylvania Quality Strategy was distributed for stakeholder and public comment through the OMHSAS Planning Council and published in the Pennsylvania Bulletin. This 2016 OMHSAS Quality Strategy will be circulated through the MH Planning Council, and comments received from stakeholders and advocates will be examined and provide the basis for further updates of the OMHSAS Quality Strategy sections within the final version of the Pennsylvania Quality Strategy.
Any significant changes to the OMHSAS Quality Strategy document will necessitate review by the behavioral health stakeholders, and the re-submission of the OMHSAS Quality Strategy document to DHS. For the purposes of definition, a significant change is defined by whether there is a federal or state statutory change in the HCBH program that would have an effect on the MMC program in Pennsylvania. The decision by the commonwealth to expand the MMC program in 2015 is a significant change thus triggering the review of the OMHSAS Quality Strategy.

The programmatic goals of the OMHSAS Strategy are reviewed each year to provide the opportunity to re-evaluate quality planning and the strategy’s success in the meeting of its objectives. This review process will assure all BH stakeholder groups that the HCBH primary contractors and BH-MCOs are evaluated systematically for compliance with all relevant federal and state regulations, and the contractual standards for the HCBH primary contractors. This process will assess whether adequate resources are committed by DHS to perform internal monitoring and contribute actively to health care improvement for the commonwealth’s most vulnerable citizens. The most current approved version of OMHSAS' Medical Assistance Quality Strategy is posted for review at: http://www.parecovery.org/omhsas_qm.shtml.

The OMHSAS Quality Strategy document will be updated as needed, and reviewed by DHS. The Pennsylvania Quality Strategy will be submitted to CMS no less than once every three years or whenever significant changes occur to the program.

b. Managed Care Quality Program Objectives

The OMHSAS quality improvement objectives were created based upon the review of statewide HCBH program results since 2007 and the review of the federal regulations as related to the Balanced Budget Act (BBA) of 1997. The objectives were also reviewed to be consonant with the Vision, Mission, and Core Values of DHS, and the Goals established by OMHSAS. The OMHSAS Goals and Guiding Principles are found in Appendix D of this document.

The decision to deliver Medicaid services within a behavioral managed care system has yielded increased penetration to mental health and drug and alcohol (D&A) services. If compared to the 2012 HEDIS®, the performance would be above the 75th percentile performance, and above the 50th percentile for the respective mental health and D&A service lines. In addition to the increased access to services, there are multiple HCBH Primary Contractor efforts to increase evidenced based practices (EBPs) in services such as High Fidelity Wrap-a-Round, Dialectical Behavioral Therapy, and extending assessment, social skills treatment, and family treatment for adolescents with autism. Other EBPs include the use of trauma-informed care, provision of peer support services, and Mobile Psychiatric Nursing Medication Management (MPNM) program. One MPNM program implemented in three rural counties has been found to

2 OMHSAS and HEDIS® penetration measures are similar but not identical.
be associated with lowered hospitalizations, lowered intensive BH services, and reducing costs of MH services by 87 percent.

OMHSAS oversees, monitors, and performs many quality activities. It has one performance improvement project with three objectives related to improving the transition from inpatient care to ambulatory care for Pennsylvania HC members hospitalized with a mental health or a substance abuse diagnosis. Other activities include performance measure collection and reporting, monitoring of operations and contract compliance, annual surveys of member and provider satisfaction done by the BH-MCOs, and satisfaction surveys done by local Consumer/Family Satisfaction Teams (CFSTs) contracted with the HCBH primary contractors. The HCBH program draws from these and other activities to identify additional programmatic goals. OMHSAS incorporates recommendations from the public, the OMHSAS Planning Council, HCBH primary contractors, BH-MCOs, and the EQRO Technical Report in setting new goals and revising the OMHSAS Quality Strategy.

In complement to the OMHSAS Quality Strategy, each HCBH primary contractor maintains and operates a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR § 438.240, and the HealthChoices Behavioral Health Program-Program Standards and Requirements (HCBH PS&R) Agreement for HCBH Primary Contractors. The QAPI is subject to yearly review and approval by OMHSAS quality reviewers. As part of their QAPI responsibility, each HCBH Primary Contractor is expected to improve in their performance measure rates, maintain compliance related to the structure and operations regulations, and to contribute to the planning and implementation of their specific BH-MCO’s PIP strategy to remediate barriers and improve service performance in their HCBH Contract service areas.

OMHSAS does not delegate the monitoring required by 42 CFR § 438.240 to the EQRO. Monitoring to determine if the HCBH Primary Contractor and BH-MCO have complied with relevant federal and state regulations, and HCBH PS&R agreement standards is done by the appropriate OMHSAS bureaus: Fiscal, Policy, Quality, Systems Management, and Operations. The HCBH primary contractors or the oversight entities coordinating the QAPI plan for multiple HCBH primary contractors hold quarterly monitoring meetings and Quality Committee meetings. The oversight of the meetings include the OMHSAS Operations and Quality members assigned by responsibility to that entity.

The quality committee meetings include beneficiaries, family representatives, CFST members, HCBH primary contractor representatives, BH-MCO representatives, OMHSAS representatives, and can include providers of services and facility representatives. This quality committee approves the HCBH primary contractor’s QAPI plan before OMHSAS reviews it as part of their compliance assessment. The goals of the local quality committee meetings are to review reporting results, discuss the results, and re-assess goals and improvement opportunities. In addition to the QAPI review, the OMHSAS Division of Quality Management holds quarterly statewide Quality Management (QM) meetings with the HCBH Primary Contractor and BH-MCO QM
Directors. The goals of these meetings are to standardize reporting, provide structure for the HCBH primary contractors and BH-MCOs to critically review the statewide quality programming, and make recommendations to improve the statewide quality processes as related to the CMS EQR mandated and optional protocols.

It is the view of OMHSAS that there is an appreciable strength to having local responsibility for quality at the HCBH primary contractor level to monitor services, satisfaction, and outcomes for

“…members whose complex medical, psychiatric, behavioral or substance abuse conditions, living circumstances and/or cultural factors necessitate specialized outreach, assistance in accessing services and/or service delivery and coordination on the part of the MCO and its Provider Network.” (Special Needs Populations definition p. xvi HCBH PS&R)

Each HCBH primary contractor is required to be responsive to local HCBH members and BH services feedback. This responsiveness along with the HCBH primary contractor QAPI review has created a complex local system with a myriad of local BH service programming to meet local HCBH membership service needs.

2. Assessment - Quality of Care provided to HCBH Members

a. The Assessment of Compliance with Federal and State Requirements

OMHSAS assesses the BH-MCO’s compliance with 42 CFR Part 438, Subparts C, D, E, and F. These subparts cover:

C - Enrollee Rights and Protections.
E - External Quality Review (EQR).
F - Grievance System.

The following activities listed below are described using five key components of quality improvement: goals, interventions, metrics, targets, transparency, and feedback. The five components change as applicable to the specific activity. This allows OMHSAS to position itself with respect to the goals, principles, and values of DHS, and to align with the health care coordination and integration priorities identified in CMS Quality Strategy 2013-Beyond and strategies as outlined by SAMHSA in Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018.

1. HCBH primary contractor/BH-MCO compliance - OMHSAS uses a monitoring instrument called the Program Evaluation Performance Summary (PEPS) to

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3 See November 22, 2013, Letter to State Health Official and State Medicaid Director.
determine compliance with 42 CFR Part 438, Subparts C, D, & F. One hundred and eight PEPS sub-standards are reviewed with multiple crosswalks to the 42 CFR Part 438 subpart categories in order to determine compliance with federal and state requirements over a rolling three-year period. The compliance determination is at the HCBH primary contractor or the BH-MCO level. OMHSAS holds the HCBH PS&R Agreement with the HCBH primary contractor, who in turn, contracts with the BH-MCO. The HCBH primary contractor is responsible for their regulatory compliance to federal and state regulations, and the HCBH PS&R Agreement compliance. The HCBH PS &R Agreement includes the HCBH primary contractor’s responsibility for the oversight of BH-MCO’s compliance with the 42 CFR § 438, Subpart E (EQR) protocols such as, the submission of performance measures and the PIPS, and Subparts C, D, and F activities delegated to the BH-MCO by the HCBH primary contractor. The mechanisms for monitoring are quarterly meetings held by the OMHSAS Bureau of Community Operations, quality committee meetings held by the HCBH primary contractors, and the EQR protocol submissions made by the BH-MCOs. The HCBH primary contractor provides reporting to the OMHSAS operational and quality reviewers prior to the meetings, and there is OMHSAS reviewer staffing at both monitoring and quality meetings.

The HCBH PS&R agreement sections and a listing of PEPS standards cross-walked to federal regulations are found in Appendix E (Quality Toolkit Review of HCBH Contract Agreement & PEPS Standards to Federal Requirements).

The following table relates the five key improvement components to PEPS reviews.
<table>
<thead>
<tr>
<th>Quality Activities</th>
<th>Goals</th>
<th>Intervention</th>
<th>Metrics PEPS Standards</th>
<th>Targets</th>
<th>Transparency &amp; Feedback</th>
</tr>
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<tbody>
<tr>
<td>HCBH Primary Contractor/BH-MCO PEPS reviews</td>
<td>Full Compliance with Standard “Met”</td>
<td>Request of a Corrective Action Plan (CAP) if Compliance Determination is “Not Met” or a decision is made by the OMHSAS reviewer to require a CAP if the determination is a “Partially Met”</td>
<td>Specific PEPS Sub-standards cross-walked to 438, Subparts C, D, and F</td>
<td>Anchors: “Met”, “Partially Met”, “Not Met”</td>
<td>Review of findings by BH-HC Contractor and BH-MCO, Corrective Action Plan (CAP) imposed by OMHSAS with the subsequent plan accepted and monitored by OMHSAS. Finally, the determination is made whether CAP is completed or continued</td>
</tr>
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</table>

Operationally, OMHSAS PEPS reviewers will often use the “Partially Met” designation to encourage the HCBH primary contractor/BH-MCO in the improvement of their processes to improve the reviewed PEPS Standard. A discussion of the finding with the HCBH primary contractor or the BH-MCO usually follows this use of the “Partially Met” result.
2. Performance Measurement reporting - The BH-MCO submits the performance measure data to the EQRO on a yearly basis. The EQRO validates the BH-MCO performance measure submissions and determines the compliance status with the federal performance measurement protocol. There are many data displays of the required performance measure results, which OMHSAS uses to monitor the HCBH program’s performance measure results and improvement, and HCBH primary contractors’ performance measure results and improvement. Examples include a performance measure ranking display, outlier performance measurement charts, and year-to-year performance and improvement charting. All displays are un-blinded by the HCBH primary contractors’ names. When appropriate to the display, the HCBH primary contractors are grouped within their BH-MCO network to give a summary view of the BH-MCOs’ performance.

OMHSAS presents the yearly results to the MH Planning Council, the HCBH primary contractors/BH-MCOs, and posts the results to PA Recovery.org (http://www.parecovery.org/omhsas_qm.shtml).

The performance measurement reporting expectations for BH-MCOs include:

a. Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge (HEDIS®).

b. PA Specific Follow-up after Hospitalization for Mental Illness within Seven and Thirty Days after Discharge (PA Specific Measure).

c. Readmission within Thirty days of Inpatient Psychiatric Discharge (PA Specific measure)⁴.

The EQRO provides the validated results back to the OMHSAS. The EQRO provides the measurement results for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure by pulling the encounters across two DHS program offices that administer the MMC programs: OMAP and OMHSAS. All of the performance measure results are reported in the EQR Technical Reports and include the HCBH primary contractor’s results for the same measures.

These results for the following measures are reported to CMS using the MACPRO system for the CHIPRA measures, and through the EQR Annual Technical Reports for the Adult Core Measures (ACM). The following National Performance Measures are reported by OMHSAS.

a. Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge (HEDIS®).

   (1) Ages 6-20 (CHIPRA).

   (2) Ages 21-64 and Ages 6-64 (ACM).

⁴ The measure specification for the PA Specific Follow-up after Hospitalization for Mental Illness within Seven and Thirty Days include PA services that are supplemental and recovery-oriented, in addition to the services covered by the HEDIS® specification for Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge.
b. Starting in the 2014 EQR BBA Technical Report, OMHSAS will report the
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
(ACM).

In addition, OMHSAS has identified the need to have additional age bands in the
Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After
Discharge (HEDIS®). These include age bands for ages 6-64, and transition age youth,
ages 15-20 and 21-25.

In previous years, the performance measure goal for Follow-up After Hospitalization for
Mental Illness within Seven and Thirty Days After Discharge (HEDIS® and PA Specific)
measures was that 90 percent of individuals discharged had a BH engagement
(encounter) within the seven and thirty days. After analyzing the four-year results from
2009 through 2012, the measures did not substantially improve. After sharing this result,
the feedback from our HCBH primary contractors and BH-MCOs was that setting an
incremental goal by year for the HEDIS® Seven and Thirty Day Follow-up After
Hospitalization for Mental Illness would more effectively improve the statewide
aggregate follow-up rates.

In 2014, OMHSAS, in collaboration with its HCBH primary contractors and BH-MCOs,
began to establish a process to set goals and targets for performance measure
reporting starting with the Follow-up After Hospitalization for Mental Illness within Seven
and Thirty Days After Discharge performance measure (HEDIS®). This process
provides a method for future incentivized performance based contracting with HCBH
primary contractors. The Goal document and the semi-annual performance measure
reporting expectations are in Appendix F.

The following table relates the five key improvement components to the Follow-up After
Hospitalization for Mental Illness within Seven and Thirty Days After Discharge (HEDIS®
methodology, ages 6-64) Performance Measure reporting.
| Quality Activities                       | Goals                                                                 | Intervention                                                                 | Metrics                                                                                           | Targets                                                                                       | Transparency & Feedback                                                                 |
|-----------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Performance Measurement reporting       | Yearly Goal setting for HCBH primary contractor and BH-MCOs           | BH-MCO Root Cause Analysis triggered by performance falling below the 75th Percentile on the HEDIS® MCO Medicaid reporting | Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge (ages 6-64) | Target based 75th Percentile on the HEDIS® MCO Medicaid reporting                             | The EQRO assesses the compliance of the performance measure protocol                           |
|                                         |                                                                       | HCBH primary contractor RCA triggered by not meeting their assigned yearly improvement change goal |                                                                                  |                                                                                                 | Results and compliance posted on DHS web site in the BH-MCO BBA Technical Report              |
|                                         |                                                                       |                                                                              |                                                                                  |                                                                                                 | OMHSAS reports the collective semiannual HCBH primary contractor results back to the HCBH primary contractors and BH-MCOs un-blinded |
3. OMHSAS PIP (2014-2018) - In 2013, the EQRO was in the last year of assessing the BH-MCO “Sustained Improvement” for the results of the Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge (HEDIS® and PA Specific) PIP. During 2013, the EQRO completed two Special Studies (optional federal protocol) on Readmission within 30 days after discharge using encounter data. The first study was a joint project with OMAP and OMHSAS. This study combined the PH and BH encounter data to obtain a more complete picture of inpatient utilization, risk factors, and multiple diagnoses associated with increased readmission rates. The second study focused on the BH readmissions within 30, 60, and 90 days after a behavioral health discharge, using only BH encounters. A BH diagnosis was defined as a mental health (MH) and substance abuse (SA) diagnosis.

The studies showed the following:

a. The initial results from the PH-BH readmission study showed that 39.2 percent of all PH index admissions had a BH diagnosis present in the previous year. These specific PH index admissions had a readmission rate that was 4.9 percentage points higher compared to those PH index admissions with only PH diagnoses in the previous year. The readmission rate was found to be 16.5 percent when the primary admission diagnosis was diabetes with a BH diagnosis in the previous year. This study continues, with additional analyses being developed and conducted.

b. The specific BH readmission study found that when a primary diagnosis of schizophrenia was present, there was a readmission rate of 10.8 percent (in 0-30 days), 16.5 percent (in 0-60 days), and 21.1 percent (in 0-90 days). There was a statistically significant readmission rate found of 11.1 percent (in 0-30 days), 16.2 percent (in 0-60 days), and 20.3 percent (in 0-90 days) when there was a co-existing MH and SA diagnoses present compared to MH or SA diagnoses separately. Finally, there was a statistically significantly lower rate in readmissions in 0-30 days for HCBH members receiving an BH engagement compared to those HCBH members that had no follow-up visit after an inpatient psychiatric discharge.

The following table relates the five key improvement components to PIP planning.
<table>
<thead>
<tr>
<th>Quality Activities</th>
<th>Goals</th>
<th>Intervention</th>
<th>Metrics</th>
<th>Targets</th>
<th>Transparency &amp; Feedback</th>
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<tr>
<td>PIP project “Successful Transitions from Inpatient Care to Ambulatory Care”</td>
<td>Reduce BH Readmissions and Substance Abuse (SA) Readmissions post-inpatient discharge</td>
<td>PIP plan interventions as developed from the collaboration between the BH-MCO and the HCBH primary contractors specific to BH-MCO barrier analysis</td>
<td>BH Readmission within 30 days of MH inpatient discharge</td>
<td>Improvement targets set by selected process measures and PIP measures reassessment of implementation plan process measures</td>
<td>Meetings held with each BH-MCO separately. Included are the EQRO, OMHSAS, and their HCBH primary contractor network to review the PIP issues found. (Frequency is TBD.)</td>
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<tr>
<td></td>
<td>Increase kept ambulatory follow-up appointments post-inpatient discharge</td>
<td></td>
<td>BH Readmission within 30 days of SA inpatient discharge</td>
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<tr>
<td></td>
<td>Improve medication adherence post-inpatient discharge</td>
<td></td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia Components of Discharge Management Planning</td>
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In 2016, OMHSAS is in the year three of the PIP. The EQR/OMHSAS meet on a quarterly basis with each BH-MCOs and their aligned HCBH primary contractors to review the PIP interventions and their results. The document outlining the PIP is in Appendix G.

4. EQR Activities – IPRO is Pennsylvania’s EQRO contractor. The current contract was signed in January 2012 and the term is for three years with two additional one-year renewals.

OMHSAS manages the review and determines the compliance status of HCBH primary contractor and BH-MCO services within the PEPS reviews, and the EQRO accepts the results for submission into the annual BH-MCO Annual EQR Technical Reports. Each HCBH primary contractor has the responsibility of oversight of the BH-MCO Performance Measure and PIP activities to meet the federal requirements. The HCBH primary contractor’s QAPI work plan also includes the PIPS and performance measure reporting for that HCBH primary contractor. The EQRO determines the BH-MCO’s compliance status with the performance measures and the PIP protocols. The mandatory and optional EQR protocols and related activities for the BH program are listed above in Section II.


In 2013, the EQRO, with OMHSAS representatives, initiated an additional optional EQR protocol, the Onsite Encounter Data Validation with the BH-MCOs. This protocol included the Informational Systems Capabilities Assessment (ISCA). The ISCA and the Onsite review resulted in the implementation of quarterly meetings with the BH-MCO’s information systems professionals and resulted in enhancements to the specifications for the performance measures. In addition, the Encounter Data Validation Protocol is expected to be a multi-year commitment by OMHSAS to increase the reliability and validity of the submitted encounters by the BH-MCOs. The Onsite EDV BH-MCO Reports are found on the same DHS link listed above, and activities are ongoing. OMHSAS manages the required and optional EQR work expectations. The following table relates the five key assessment components to EQRO Activities. The OMHSAS review of the 2013 EQR Technical Report is in Appendix H using the EQR Toolbox.
published by CMS. On the basis of the OMHSAS review, the 2015 EQR Technical Reports were updated in language and formatting to provide more transparency of the BH MMC system overseen by OMHSAS. Multiple year EQR Technical Reports are posted on the DHS link above for review and comparison.

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b. Other Quality Activities

1. Consumer Satisfaction

The assessment of HCBH members’ satisfaction with services is reported at multiple system levels. The BH-MCOs report on consumer satisfaction of their members annually. Each HCBH-MCOs report on consumer satisfaction of their members annually. Each HCBH primary contractor contracts with a Consumer and Family Satisfaction Team (CFST) that conducts a local satisfaction survey, with results reported through local quality team meetings on an annual or semiannual basis depending on the HCBH primary contractor’s QAPI plan. Each CFST team also reports a quarterly summary based on uniform questions for adults and for children/family members to OMHSAS. The three questions assessed statewide are whether adults/children or their family members were able to get help, were involved in treatment decisions, and if their treatment had improved the quality of their lives (at least somewhat). OMHSAS also conducts an annual statewide survey using the Pennsylvania version of the Mental Health Statistics Improvement Program (MHSIP). The statewide summary results from the PA MHSIP are in Appendix J.

2. Race, Ethnicity, and Primary Language

Pennsylvania currently obtains race (multiple categories), Hispanic ethnicity, and the primary language spoken during the eligibility assessment of the Medicaid enrollment process. This information is obtained from the individual's self-report. The
BH-MCOs receive the race, ethnicity, and primary language information from the state on a daily and monthly basis through eligibility data files.

A required part of PEPS reporting is that each BH-MCO is required to have a list of interpreters, and track the use of interpreters and translation services during the year. When the BH-MCO membership is assessed at 5 percent or higher for a particular language-speaking population, the BH-MCO is required to have access to a customer line and printed HCBH materials in that language.

The EQRO completes an analysis on the validated performance measure data for race, age, gender, and ethnicity disparities. When a disparity is statistically determined, the EQRO reports this in the Performance Measure Reports issued at the BH-MCO and the HCBH primary contractor level.

3. Information Management, other than identified above.

a. The Role of Health Information Technology in the BH HealthChoices Program

Pursuant to the HCBH PS&R agreement, the HCBH primary contractors and their BH-MCOs are required to have management information systems capable of collecting, analyzing, and submitting all Pennsylvania DHS required data and reports. The state ensures compliance through an initial readiness review, ongoing conference calls, and ad hoc reviews.

OMHSAS monitors the accuracy, timeliness, and completeness of the BH-MCO data submitted. Data is utilized by OMHSAS as part of its ongoing quality assurance activities. The data is also used for reporting to state, federal, and public entities.

Each BH-MCO is provided person-level eligibility information on their members, as well as Medicaid-enrolled behavioral health provider data. Additional data supports, as identified within the HCBH PS&R agreement, are afforded the BH-MCOs to assist them in fulfilling their data reporting requirements.

BH-MCOs are required to submit encounter data to DHS in a manner consistent with HIPAA-compliant 837 transactions.

OMAP/OCQI works with BH providers and groups to increase participation in the MA EHR incentive program. Additionally, grants have been made available to BH groups to onboard to Health Information Organizations (HIOs) to enhance HIE in Pennsylvania. There have been discussions on potential future grant opportunities.

1) Health Information System

As part of its HCBH PS&R agreement with HCBH primary contractors, OMHSAS requires contractors to report an array of non-financial information. Included in the reporting for the Medicaid managed behavioral health program are the following:

a) Detailed information on the contractor’s provider network (submitted in a DHS proprietary format).
b) Aggregate-level data on member complaints and grievances (submitted in DHS proprietary format).
c) Member-level encounter data (submitted in HIPAA-compliant 837 transaction formats).
d) Aggregate-level information on Therapeutic Staff Support authorization and payment grievances (submitted in an OMHSAS proprietary format).
e) Aggregate-level Quarterly Monitoring data (submitted in an OMHSAS proprietary format).

A list of the (non-financial) data reporting requirements for the HCBH primary contractors is found in Appendix K of this document.

To assist the HCBH primary contractors in fulfilling their data reporting requirements, OMHSAS provides the contractors targeted inquiry access to DHS’ eligibility system, eligibility verification capabilities, and a range of data support files, including:

1. Daily and monthly eligibility files (transmitted in HIPAA-compliant 834 transaction formats).
2. Third Party Liability file (transmitted in a DHS proprietary format).
3. Medicaid Provider file (transmitted in a DHS proprietary format).
4. Diagnosis Code file (transmitted in a DHS proprietary format).
5. Procedure Code file (transmitted in a DHS proprietary format).

The data supports listed above (as well as additional information) are essential resources for the HCBH primary contractors (and their subcontractors) to meet the HCBH program’s data reporting expectations. Additionally, the BH-MCOs receive pharmacy data files from DHS that are provided by the PH-MCOs. These data files enable the BH-MCOs to have a better understanding of the beneficiary medical complexity, medication adherence, and drug-drug interactions.

The reporting noted above, as well as additional information is utilized by OMHSAS as quality management resources in the ongoing monitoring of the effectiveness and compliance of the statewide program.

4. Improvements and Interventions

a. Telepsych Services (psychiatrist and psychology services only)

The OMHSAS telepsych initiative is based on the use of real-time, two-way interactive audio-video transmission to enhance accessibility to psychiatric and psychological services. Telepsych services are covered for psychiatric diagnostic evaluations, psychological evaluations, consultation, pharmacological management, patient/family consultations, and psychotherapy services when the county mental health program and the BH-MCO approve the provider’s service plan. The provider must also have an OMHSAS-approved program description and be enrolled in the MA program. The 2010 Census determined that there are 54 rural counties in Pennsylvania, and 19 of those
counties are currently designated as mental health professional shortage areas (MHPSA). The HCBH Program has provided access to psychiatry/psychological services via telepsych in 89 percent (17/19) of these designated areas as of 2014.

b. Improvement, Expansion, and Evidenced Based Practices

OMHSAS has not only added a new medium of service delivery through telepsych service, but has developed other enhancements and added evidence-based practices (EBPs) to the service array. A Mobile Mental Health Treatment service has been added to the list of services provided in outpatient clinics to serve members with issues of mobility. Various grants were received to develop EBPs and promising practices such as Psychiatric Rehabilitation Services (PRS), both site-based and mobile, Peer Support Services (PSS), and Assertive Community Treatment teams (ACT). These services were developed and brought into the HCBH Program as important contributions to the improvement of the quality of services available to members in the program. In addition, a SAMHSA grant was received to promote and develop Self-Directed Care. Other grants related to housing help in the development of Supportive Housing and Supported Employment programs throughout the state.

c. Certified Community Behavioral Health Clinics Grant

Pennsylvania was awarded a planning grant by SAMHSA (RFA No. SM-16-001) to create Certified Community Behavioral Health Clinics (CCBHC) to improve the behavioral health of Pennsylvanians by providing community-based mental health and substance use disorder treatment. The clinics will provide intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services. This planning grant will allow DHS to apply for the two-year demonstration grant. In December 2016, Pennsylvania was selected as one of eight states to participate in the CCBHC Demonstration grant. The 10 clinics selected by the Department to participate in this grant begin on July 1, 2017.

d. Health Information Technology

The HCBH PS&R agreement outlines submission expectations for the BH-MCO’s Performance/Outcome Management System (POMS). The POMS is a DHS database that is managed and updated using the extensive raw data concerning BH-MCO enrollees. These data areas are used to meet accountability in capitation payments, to develop outcome oriented incentives and sanctions, and supports evidence of a collaborative Continuous Quality Improvement process. The POMS information is found in Appendix L. Additionally, OMAP and OMHSAS are jointly working to enhance data exchange between the PH-and BH-MCOs. Currently the PH-MCOs receive BH claims data (minus HIV and drug/alcohol related information) from DHS. The BH-MCOs receive pharmacy claims data from DHS. In the future, the BH-MCOs will receive PH claims from DHS. This data exchange will facilitate better care coordination.
e. Intermediate Sanctions

The HCBH PS&R agreement that OMHSAS holds with the HCBH primary contractors outlines the sanctions and penalties that maybe imposed for failure to meet performance and program standards as outlined. These sanctions and penalties include but are not limited to:

1) Requiring the primary contractor to submit a corrective action plan.
2) Imposing monetary penalties, including suspension or denial of payments.
3) Terminating the agreement.


5. Conclusions and Opportunities

a. Conclusions

OMHSAS is complying with the regulations found in 42 CFR Part 438 concerning enrollee rights and protections, access, structure and operations, measurement and improvement, external quality review, and grievance system. This assessment was based upon a crosswalk of the regulations with the HCBH PS&R agreement provisions and the PEPS Standards assessed by OMHSAS. Finally, the EQR Annual Technical Reports were reviewed using the EQR Toolbox provided for States provided by CMS. These reports met the EQR regulatory requirements. The new EQR protocol activities done in the 2013 calendar year will be described to the 2014 EQR Annual Technical Reports.

Improvements made to the performance measures and the PIP mandatory protocols within the past two years include beginning to benchmark goals for HCBH primary contractors and BH-MCOs to reported HEDIS® Medicaid rates, and creating a new PIP to impact the successful transition of members from BH Inpatient Care settings to Ambulatory Care settings. These efforts afford the opportunity to begin studying the use of incentivizing payments based on measured performance standards and further BH-PH managed care collaboration in reducing readmissions.

b. Opportunities

The majority of the individuals newly eligible for the BH MC program in 2015 were 21-75+ years of age. In addition, “Pennsylvania now leads the nation in drug overdoses among men ages 12 to 25, and ninth in the country among the general population” (see Centers of Excellence. http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_230391.pdf).
OMHSAS will work with our provider and payer partners, as well as the Department of Health and OMAP, to expand mental health and substance use screening and treatment strategies within the program offices. The CCBHC Demonstration grant will provide greater integrated services for individuals with serious mental illness and substance use disorders. Another opportunity in treatment service development is the OUD-COE. This initiative is expected to improve medication assisted treatment (MAT) of opioid use disorders using evidenced-based practices, and assure the coordination of care including PH and BH care needs.

Behavioral and physical health integration necessitates sharing of data between the two managed-care programs enabling the plans and providers to more effectively and more robustly manage complex medical issues. Pennsylvania, through the eHealth Partnership Authority, is working to develop interconnections of the regional HIEs which will allow the appropriate sharing of information to effectively treat and manage complex medical issues.

Although BH providers were excluded from the Medicare and Medicaid Electronic Health Record Incentive program, a significant number of PA BH providers have purchased EHR systems; although the majority do not have interoperable connectivity to an HIE. DHS’ goal is to incentivize HealthChoices providers to connect with their regional HIE. The target is to be at 80 percent connectivity by 2019.

DHS has dedicated over $17 million to develop and implement community based care management teams, which will assist individuals in navigating their complex medical conditions within the physical, mental health, and substance use areas.
B. Community HealthChoices (CHC)

iii. Office of Long-Term Living (OLTL)

1. Introduction

OLTL partners with participants, providers, families, and local, state, and federal government to develop and administer programs to support the long-term living needs of older Pennsylvanians and adults with physical disabilities.

OLTL is responsible for the statewide administration of Pennsylvania’s long-term living programs and services for low-income older adults and adults with physical disabilities. The commonwealth serves over 95,000 adults needing long-term services and supports (LTSS) through five Medicaid-funded 1915(c) HCBS waivers, nursing facilities, the Living Independence for the Elderly (LIFE) program, known nationally as the Program for All-Inclusive Care for the Elderly and the state-funded Act 150 Attendant Care program. In total, the commonwealth spends approximately $5 billion annually on publically-funded LTSS. In addition, OLTL responsibilities include assessing and improving the quality of services received by participants in various long-term living settings and monitoring fiscal and regulatory compliance. While OLTL currently operates a fee-for-service system, over the course of the next three years, OLTL intends to move to a managed long-term services and supports delivery system. The following is OLTL’s proposed structure detailing the bureaus that will administer the HCBS program:

Deputy Secretary’s Office (DSO): The deputy secretary plans, coordinates, and directs the provision of DHS LTSS benefits and services throughout the commonwealth; consults and cooperates with federal and state government, private agencies, and associations on the delivery of LTSS to ensure that the quality of and access to these services are in compliance with federal and state regulations and resources; and recommends changes in law and regulations for nursing facilities, HCBS, LTSS, and LIFE programs. The deputy secretary is involved in the leadership and strategy of the development and coordination of DHS’ Quality Management (QM) program. The deputy secretary delegates some responsibility for the implementation of the QM plan to the medical director and bureau directors leading each of the bureaus. However, ultimate accountability for the quality of care and services given to participants is retained by the deputy secretary. The deputy secretary will oversee a Launch Monitoring Steering Team for intensive monitoring of the new managed LTSS delivery system implementation, known as Community HealthChoices (CHC). The Launch Monitoring Steering Team will include bureau directors, quality managers, contract managers, and other key personnel. This will include daily calls with CHC-MCOs and regular calls with stakeholders.

Bureau of Participant Services (BPPS): Effectively operationalizes home and community-based waiver programs through oversight of participant enrollment functions; oversees the nursing home transition, incident management system,
independent enrollment broker, participant helpline, and provides subject matter expertise for readiness review and monitoring of the CHC-MCOs in the areas of service coordination, participant complaints and grievances; review and approval of individual service plans; and provision of programmatic guidance to service coordinators and providers. Also manages the participant helpline and provides assistance to service coordinators on protective services cases.

**Bureau of Quality Assurance and Program Innovation (BQAPA):** Conducts quality management and improvement monitoring of CHC. This includes CHC-MCOs’ compliance with federal and state regulations, the delivery of quality programs to ensure the health and welfare of beneficiaries, and program and service delivery systems achieve desired outcomes.

Duties include the management of data analysis to measure the effectiveness of program design and operations and support OLTL bureaus in need of statistical analysis, data reports, utilization analysis, and process development in conjunction with the OLTL medical director. BQAPA oversees the analysis of data obtained through beneficiary satisfaction surveys, provider performance measures, and works closely with the EQR vendor. BQAPA provides subject matter expertise on readiness review and monitoring of the CHC-MCOs in the areas of quality assurances and quality management.

Additionally, the BQAPA will design hypotheses and identify research projects with both Medicare and Medicaid data to evaluate the effectiveness of OLTL programs and initiatives, and recommend improvements based on findings. BQAPA will work closely with all OLTL bureaus, including the medical director, in support of activities related to incident management and risk reduction, Prior Authorization Review Panel (PARP) process for the managed care system, schedule QQRMs with CHC-MCOs, and the data collection vendors and systems.

**Bureau of Contract Management and Provider Support (BCIS):** Responsible for the administration and oversight of the CHC-MCOs that provide managed long-term services and supports to eligible beneficiaries. BCIS provides subject matter expertise on readiness review and monitoring of the CHC-MCOs.

- Assesses changes in state or federal regulations to identify impact on the CHC-MCOs’ programs and agreements.
- Manages the financial management contract which provides payroll assistance to participants of the self-directed model of care.
- Negotiates agreements with MCOs and contracts with other vendors that support bureau functions.
- Imposes program sanctions and penalties, where appropriate.
- Directs corrective action plans for the CHC-MCOs and other contractors.
- Coordinates all managed care provider enrollment, licensing, and revalidation activities.
• Oversees the utilization review process of nursing facilities enrolled as Medicaid managed care providers.

Bureau of Policy Development and Communication Management (BPDCM):
Supports the strategic policy and communication goals across all functional bureaus and the deputy secretary’s office. BPDCM is responsible for the planning, coordination, evaluation, and development of policy activities across OLTL, as well as coordinating internal and external communication with stakeholders. In performing its responsibilities, the bureau serves as a liaison with other DHS programs and policy offices, Pennsylvania state agencies, and other external stakeholders. Staff is responsible for supporting all functional bureaus in developing consistent policy, evaluating impact, and improving strategic direction, as well as submitting state plan and waiver documents to the federal government.

BPDCM will assess the needs for policy changes and regulatory guidance. This includes the review and analysis of state and federal policies for impact on OLTL programs; the formulation of policies; the development of regulatory guidance and the preparation of regulations, statements of policy, rate notices, waiver renewals and amendments, OLTL bulletins and other policy documents required to implement policy change and initiatives.

Additionally, the bureau will manage the LTSS and Managed Care LTSS subcommittees of the MAAC; preparing communications for internal and external and external stakeholders; coordinating internal and external training; and managing the review, processing, and publication/submission of notices, regulations, State Plan Amendments, waiver renewals and amendments, and other policy documents required to implement policy change and initiatives.

Bureau of Finance (BOF): Responsible for financial operational management of the waivers and ongoing monitoring of expenditures and related information. Oversees and develops CHC-MCO capitation rates and provides budget analysis to help inform policy decisions. BOF also provides oversight on the day-to-day financial monitoring of OLTLs appropriations and operating budget. This office serves as the liaison to the DHS Budget Office and the Governor's Budget Office to ensure that the appropriations for the OLTL programs are adequate. BFO is also responsible for the following:

• Develop, monitor, and update the budget through the annual Budget cycle for all of the state and federal appropriations that support the various OLTL programs.
• Identify and investigate trends and potential budget opportunities and risks.
• Conduct financial analysis for programs and waivers.
• Serve as liaison to the DHS Budget Office and Governor's Budget Office.
• Monitor contracts to track expenditures and ensure compliance of OLTL contractors and ensure contract effectiveness.
• Responsible for the processing of invoices, accounting for collected revenues, and for the proper use of fees from assessment programs, civil monetary penalties, and gross receipts.
- Payments for OLTL’s operating contracts, the Nursing Home Transition program, OLTL’s operating expenses, and other miscellaneous payments.
- Process supplemental and special payments and oversee the monitoring of MCO encounter data, claims management, and payments.
- Review MCO financial statements for financial stability, revenue and cost reporting, and utilization to assist DHS’ actuary in developing rates.

Beginning with the second year of CHC program implementation, both the BQAPA and BFO will work collaboratively to develop value-based payments.

a. History of the Community HealthChoices Program

The current LTSS system has many challenges: LTSS sometimes lack coordination; the eligibility process is lengthy and complicated; inefficiencies in service delivery can result in unnecessary costs; provider reimbursement methodologies are inconsistent; funding and service silos can hinder maximization of existing resources; and lack of technology coupled with inadequate or outmoded data, metrics and tools, hamper efforts to assess and ensure quality services.

To enhance care coordination, service delivery, and quality outcomes for Pennsylvania’s seniors and individuals living with physical disabilities, OLTL plans to move to a managed care delivery system for participants currently receiving long-term services and supports.

CHC will be the commonwealth’s statewide mandatory managed care program for Medicaid-eligible adults needing long-term services and supports and for full dual-eligible beneficiaries. Participants will receive all Medicaid physical health services and LTSS through CHC. This initiative builds on the commonwealth’s past success in implementing the country’s most extensive network of Programs of All-inclusive Care for the Elderly (called LIFE, Living Independence for the Elderly, in Pennsylvania), which will continue to be an option for eligible persons, and four HCBS waiver programs, which will be replaced by CHC. It also builds on the commonwealth’s experience with HealthChoices, the statewide managed care delivery system for children and adults. Behavioral health services will continue to be provided through the behavioral health services HealthChoices. CHC-MCOs and BH-MCOs will be required to coordinate services for individuals who participate in both programs.

CHC will serve the following individuals:

- Adults age 21 or older who require MA LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility.

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5 The four waiver programs that will be combined in CHC are: Aging, Attendant Care, CommCare, and Independence.
• Individuals eligible for full MA benefits and Medicare (dual-eligibles) age 21 or older whether or not they need or receive LTSS, excluding participants who are enrolled in OLTL’s OBRA waiver or a HCBS waiver administered by the Office of Developmental Programs.

The commonwealth plans to coordinate health and LTSS through CHC managed care organizations. The CHC rate model will include value-based incentives to increase the use of HCBS and meet other program goals in upcoming years. CHC will use standardized outcome measures at both the program and participant level to assess overall program performance and improve the CHC program over time. Measures to ensure ongoing improvements to the CHC model will include stakeholder engagement to provide participant input.

CHC will serve an estimated 420,000 unduplicated individuals, including 130,000 older persons and adults with physical disabilities who are currently receiving LTSS in the community and in nursing facilities over the course of a year. CHC-MCOs will be accountable for most Medicaid-covered services, including preventive services, primary and acute care, LTSS (HCBS and nursing facilities), prescription drugs, and dental services. Participants who have Medicaid and Medicare coverage (dual-eligible participants) will have the option to have their Medicaid and Medicare services coordinated by the same MCO.
The CHC program will be implemented in three phases over the next two years. Phase One is scheduled to be implemented in January 2018 and will encompass the Southwest zone; Phase Two is scheduled to be implemented in July 2018 and will encompass the Southeast zone; and Phase Three is scheduled to be implemented in January 2019 and will encompass the Lehigh/Capital zone, the Northwest zone, and the Northeast zone. The CHC zones are consistent with the physical health HealthChoice zones.

The program’s five goals are as follows:

**Goal 1:** Enhance opportunities for community-based living. There will be improved person-centered service planning and, as more community-based living options become available, the ability to honor participant preferences to live and work in the community will expand. Performance incentives built into the program’s quality oversight and payment policies will stimulate a wider and deeper array of HCBS options.
**Goal 2:** Strengthen coordination of LTSS and other types of health care, including all Medicare and MA services for dual-eligibles. Better coordination of Medicare and MA health services and LTSS will make the system easier to use and will result in better quality of life, health, safety, and well-being.

**Goal 3:** Enhance quality and accountability. CHC-MCOs will be accountable for outcomes for the target population, responsible for the overall health and long-term support for the whole person. Quality of life and quality of care will be measured and published by DHS, giving participants the information they need to make informed decisions.

**Goal 4:** Advance program innovation. Greater creativity and innovation afforded in the program will help to increase community housing options, enhance the LTSS direct care workforce, expand the use of technology, and expand employment among participants who have employment goals.

**Goal 5:** The CHC program will increase the efficiency of health care and LTSS by reducing preventable admissions to hospitals, emergency departments, nursing facilities, and other high-cost services, and by increasing the use of health promotion, primary care, and HCBS.

b. Managed Care Goals, Objectives, and Overview

Within OLTL, the BCIS is responsible for the administration and oversight of the CHC program, including monitoring the managed care contracts to ensure that the CHC-MCOs are meeting program requirements and performance targets. There are three key areas within OLTL responsible for the oversight of most activities identified in this Pennsylvania Quality Strategy for the LTSS component:

1. The BQAPA, responsible for the overall quality program of CHC-MCO performance.
2. The BCIS, responsible for monitoring and enforcing CHC-MCO compliance with their agreements to support program performance.
3. The BOF, supports all OLTL bureaus to review and advise on the CHC-MCO solvency and provides financial support in support of CHC operations.

OLTL plans to meet regularly with CHC-MCOs to discuss operations issues and to apprise the CHC-MCOs of administrative changes and updates that may have an
impact on service delivery. In addition, OLTL will work closely with OMAP, who manages the existing HealthChoices program, and implement a quarterly quality component to ensure that there are devoted meetings with each individual MCO – the QQRMs – to discuss key quality indicators, best practices, and areas for improvements. The basis of these meetings will be an open, creative, collaborative dialogue with OLTL and the CHC-MCOs with an emphasis on quality outcomes.

In the area of monitoring of quality and performance, OLTL will monitor CHC-MCOs areas as follows:

- Assess changes in state or federal regulations to identify impact on the CHC-MCOs programs and agreements.
- Manage the financial management contract, which provides payroll assistance to participants of the self-directed model of care.
- Negotiate agreements with managed care organizations and contracts with other vendors that support bureau functions.
- Impose program sanctions and penalties, where appropriate.
- Direct corrective action plans for the CHC-MCOs and other contractors.
- Coordinate all managed care and fee-for-service provider enrollment, licensing, and revalidation activities.
- Oversee the utilization review process of nursing facilities enrolled as Medicaid managed care and fee-for-service providers.

In addition, OLTL will work closely with other program offices regarding clinical and quality improvement areas. This will include all program office chief medical officers and the OMAP chief dental director. This staff will also have the lead for the HIT efforts for the commonwealth.

c. Development and Review of the Quality Strategy

On April 27, 2016, an internal OLTL team began collaborative discussions on the development of its overall Pennsylvania Quality Strategy. The Pennsylvania Quality Strategy document aligns with the requirements of 42 CFR § 438.204. Upon completion of the draft strategy document, a two-week internal review process was undertaken. In early October, the proposed draft Quality Strategy was shared with upper management staff within DHS for final review. When finalized, the document began the 30-day public comment review period after the publication of a public notice in the PA Bulletin. In addition, the Pennsylvania Quality Strategy was sent to the Chairs of the MAAC and its Subcommittees and was posted on the DHS web site for public review and comment.
2. Assessment

a. Quality and Appropriateness of Care

DHS’ goal through the implementation of CHC is to deliver improved quality and coordination of care and services that enable, maintain, or improve their health and quality of life. The CHC-MCOs will be expected to provide quality LTSS to participants and promote improvement in the quality of care provided to participants through established quality management and performance improvement processes. Under the CHC Agreement, CHC-MCOs will be required to have written quality management strategies and quality improvement programs that clearly define quality improvement structures and processes through the assignment of responsibility to appropriate individuals. CHC-MCOs will also be required to meet both national and state specific quality measures (see Appendix N).

All CHC-MCOs will be required to include at a minimum, as outlined in the draft CHC agreement, the following in its QM program (see Appendix M):

- A written Quality Assessment and Performance Improvement plan completed on an annual basis with quarterly updates.
- Monitoring and evaluation activities which include peer review and Quality Management Committee.
- Protection of participant records.
- Communicate and honor to participant rights and responsibilities as outlined in the CHC-MCO agreement.
- Tracking and trending participant and provider issues.
- Mechanism to assess the quality and appropriateness of care furnished to participants.
- Performance improvement programs.
- Submission of participant's specific data.
- Reporting on designated quality measures to identify outcomes and trends and describing how trends will be addressed.
- Procedures outlining how and when information will be entered into the DHS quality data reporting system.
b. Procedures for Race, Ethnicity, Disability, and Primary Language Data Collection

The CHC-MCOs and providers are contractually required to demonstrate cultural competency, including competency in all types of disabilities for adults of all ages. CHC-MCOs and providers must be willing and able to make necessary distinctions between traditional treatment methods and nontraditional treatment methods that may be equally effective and are more consistent with the member's racial, ethnic, or cultural background. CHC-MCOs and providers must demonstrate consistency in providing quality care across a variety of races, ethnicities, and cultures.

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

In addition, OLTL will request the CHC-MCOs to submit participant level HEDIS® data files as part of the overall HEDIS® audit process. OLTL will utilize this data to evaluate potential CHC-MCO disparities within the specific HEDIS® measures that are reported and also may review the information in comparison across CHC zones. Observations from the participant-level data will be identified and used for discussions with the CHC-MCOs during the QQRMs. When presenting the participant-level data, the CHC-MCO must make certain footnotes indicating results that may not be consistent across all measures, i.e., rates produced from small denominators can produce rates with greater variability or greater margin of error.

c. National Performance Measures

The CHC-MCOs will provide Quality Assessment and Performance Improvement Programs consistent with federal guidelines under Title XIX of the SSA, 42 CFR Part 438, Subpart D.

The CHC-MCOs must be accredited by NCQA or by a national accreditation body and obtain accreditation within the accreditation body's specified timelines. Annually, the CHC-MCO must complete all adult HEDIS® measures designated by NCQA as relevant to Medicaid. The only exclusions from the complete Medicaid HEDIS® data set must be childhood related and pregnancy related measures. The HEDIS® measure results must be reported separately for each zone in which the CHC-MCO operates. The CHC-MCO must contract with an NCQA certified HEDIS® auditor to validate the processes of the CHC-MCO in accordance with NCQA requirements.
d. Monitoring and Compliance

Because CHC will be implemented starting in January 2018, OLTL will meet regularly with CHC-MCOs to discuss operations issues and to apprise the CHC-MCOs of administrative changes and updates that may have an impact on service delivery. We will mirror the existing HealthChoices program, and implement a quarterly quality component to ensure that there are devoted meetings with each individual MCO – the QQRMs – to discuss key quality indicators, best practices, and areas for improvements. The basis of these meetings will be an open, creative, collaborative dialogue with OLTL and the CHC-MCOs with an emphasis on quality outcomes. The QQRM is an opportunity to:

- Review the CHC-MCO performance against stated goals.
- Investigate causes of missed goals and targets.
- Implement corrective action steps for missed targets.
- Establish new targets.

In addition, OLTL has partnered with the University of Pittsburgh, who will conduct a multi-method, multi-year independent evaluation of CHC. The evaluation will have three major data collection and analysis methods: qualitative research using focus groups and key informant interviews, interviews with representative samples of program participants and caregivers, and analysis of administrative data. This data will be used to examine the implementation, process, and outcomes of CHC for all target populations. The evaluation will have goals and primary research questions, data collection methods and analytic strategies, timeline, communication and deliverables, and governance. On or about June 3, 2016, OLTL first published a draft of the evaluation plan for public comment. Comments were reviewed and incorporated into the latest version of the plan (visit http://www.dhs.pa.gov/citizens/communityhealthchoices/index.htm#.VowArU1i71 to view the current plan).

The below graph provides a snapshot of how OLTL will coordinate each inter-related evaluation and monitoring role overseeing the CHC program implementation. This will help ensure CHC-MCOs are ready to provide services, identify unanticipated implementation challenges, address them in real time, and conduct annual and ongoing monitoring of CHC-MCOs.
Readiness Review - OLTL will ensure that every selected CHC-MCO will be ready to accept enrollments, provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers, and fully meet the diverse needs of the Medicare-Medicaid and LTSS population. Every selected CHC-MCO must pass a comprehensive readiness review. The readiness review process will include a specific focus on those areas and processes that directly impact participant's care including assessment processes, care coordination, provider network development and maintenance, including staff and training. OLTL will work collaboratively with OMAP, the program office responsible for the HealthChoices program, to develop a state-specific readiness review tool based on their experience, their existing tool, and existing tools from other states.

Early Implementation Monitoring - the priority for early monitoring of CHC is to ensure continuing care for all participants. The following framework outlines the key components of OLTL’s early detection and mitigation strategy. It will be utilized during the beginning of each rollout phase.

- Participants continue receiving services. Ensure the safety and well-being of participants, with a particular emphasis on successful participant enrollment and continuity of LTSS services in the transition.
- Providers continue delivering services and are paid. Ensure that all providers delivering CHC covered services for enrolled participants continue to provide services and are paid promptly by CHC-MCOs, whether or not they join MCO networks.
• CHC-MCOs will ensure that participants are assigned a service coordinator in a timely fashion. Service coordinators will be required to contact participants within required timeframes to assess needs and to provide contact information.
• Networks are robust. Provider networks are adequate to serve the enrolled membership, and participants are able to access services of all types. MCOs building networks and are converting out-of-network providers to network providers.
• Communication is effective. All stakeholders have heard of CHC and have the information they need, or know where to get it.
• Information systems are effective. Critical information flows without interruption. Systems operated by DHS, MCOs, the Independent Enrollment Broker, the Clinical Eligibility Determination Entity, and providers are interoperable.
• Lessons are applied. Problems are analyzed and systemic solutions are implemented.

Priorities for early monitoring will be finalized after the readiness review process. In the course of conducting readiness reviews, OLTL will identify areas of concern, some of which will be universal and others of which will be MCO-specific. This will guide OLTL priorities for early monitoring and may result in additional data requests from MCOs and EQRO to address the areas of concern.

**Monitoring of Quality and Performance**

BQAPA's work consists of quantifying, analyzing, trending, and making initial recommendations regarding priorities and specific quality improvements to OLTL systems, and then monitoring system improvement changes for effectiveness. BQAPA, BPO, and BCIS work collectively to review data that has been compiled from the CHC-MCOs, on-site OLTL monitoring, and the EQRO. This data is utilized to identify issues, trends, and quality oversight, and is used in waiver reporting.

The process for trending discovery and remediation information (data) begins with BQAPA receiving data from various points in the OLTL system as well as from the contracted EQRO and the CHC-MCOs. Reports will be created by BQAPA to trend various aspects of quality including administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. BQAPA will convene monthly internal Quality meetings as well as implement a quarterly quality component to ensure that there are devoted meetings with each individual MCO, the QQRMs, in order to discuss key quality indicators, best practices, and areas for improvements. The basis of these meetings will be an open, creative, collaborative dialogue between OLTL and the CHC-MCOs with an emphasis on quality outcomes. The QQRM is an opportunity to review:

- CHC-MCO performance against stated goals.
- Investigate causes of missed goals and targets.
- Implement corrective action steps for plans that missed targets.
- Establish new targets.
In order to prioritize quality management issues, BQAPA has assigned each of the five waiver assurances to a quality management liaison to review various quality reports through tracking and trending, and determine possible causes of aberrant data or compliance issues. Quality data is gathered for performance measures from numerous sources, including OLTL discovery and remediation activities, on-site provider monitoring by the OLTL, as well as internal OLTL activities/reporting. This information is aggregated for tracking and trending. The QM liaison makes initial recommendations and prioritizes issues for problem-solving or corrective measures. The QM liaison reviews and responds to aggregated, analyzed discovery and remediation information collected on each of the assurances. In addition to trending and analyzing, this structure allows BQAPA to review for possible internal OLTL systemic changes and to identify possible program training or technical assistance needs.

BQAPA internally reviews the assessments made by the QM liaison. For those issues that are considered critical by the QM liaison, an expedited process of review is implemented. The QMU summarizes the list of priorities and recommendations in a monthly report to present at monthly Quality Management Meetings and will be attended by key personnel from all OLTL bureaus. The comments from the quality meetings are considered and included in a revised report for discussion with the MCOs during weekly update meetings. OLTL bureau directors will collectively submit final recommendations as to any action needed for system improvements to the deputy secretary of OLTL. The implemented system improvements return to the quality cycle through monitoring and remediation.

In addition, BCIS will monitor CHC-MCO agreements, review and approve subcontracts, identify areas of non-compliance, approve corrective action plans, and recommend sanctions and penalties where appropriate. The division will also monitor the CHC-MCOs to ensure the provision of a fair enrollment process into the provider network. This will include the following:

**Independent Evaluation** – The University of Pittsburgh will conduct an independent evaluation of CHC. This evaluation will also fulfill the CMS requirement for an independent assessment under the 1915(b) waiver. The evaluation will have the following characteristics.

- **Rigorous.** The evaluation uses methods designed to achieve valid and unbiased results.
- **Independent.** The evaluator is external to and independent of DHS and has no direct or financial relationship with any of the CHC-MCOs.
- **Transparent.** Evaluation plan and results will be shared with stakeholders.

An evaluation plan outlines the goals and methods of the evaluation, and how DHS will disseminate information about the evaluation to promote transparency. The evaluation plan lays out the overall blueprint for the evaluation. It will evolve over time as the CHC program is refined through the availability and quality of specific data sources as they are identified and confirmed. The evaluation will also include primary data collection.
(surveys, interviews, and focus groups) from stakeholders at various points in time. In order to avoid duplication and confusion, the University will coordinate with DHS when scheduling primary data collection. DHS will provide information to stakeholders about the status and results of the evaluation via the MAAC, relevant subcommittees, and through web postings. The evaluation plan was posted for public comment and will be updated as it evolves.

To achieve program goals, DHS is working to establish baseline measurements and will be working to refine its performance measures to ensure that they align with these goals. The University of Pittsburgh will also ensure that the independent evaluation addresses these five goals. To view the current plan, visit http://www.dhs.pa.gov/cs/groups/webcontent/documents/plan/c_250592.pdf.

e. Clinical Guidelines

OLTL requires that each of the CHC-MCOs Quality Management and Utilization Management Programs include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services. The programs must include professionally developed practice guidelines of care written in measurable and accepted professional formats, based on scientific evidence and applicable to providers for the delivery of certain services. Practice guidelines must address the full range of health care needs of the populations served by the CHC-MCO, and must be reviewed at least annually and approved by the CHC-MCO's internal Quality Improvement Committee (see Appendix M).

f. External Quality Review Organization

DHS will contract with an EQRO to perform the mandated standard external quality review activities that are required as part of 42 CFR § 438. These activities include: Performance of an annual EQR of each contracting MCO or PIHP, Validation of Performance Improvement Projects, Validation of MCO Performance Measures, Reviews of MCO Compliance with Monitoring Standards, Validation of Encounter Data, Validation of Beneficiary/Provider Surveys, and Validation of other Pennsylvania Performance Measures (as designated by DHS). The results of these EQR activities will contribute to updates to the Pennsylvania Quality Strategy.

3. State Standards

a. Access Standards

A key component to achieve OLTL’s goals is to ensure timely access to needed services for all participants. OLTL will require MCOs to provide several reports related to access (see Appendix O). These data elements are necessary to measure performance against program standards. The CHC-MCOs submit the results using state-specific definitions and required timeframes for calculation and reporting.
b. Standards

To provide appropriate access to care for CHC participants, all standards for access to care, structure, operations, and quality measurement and improvement are referenced throughout the Quality Strategy document and were incorporated in the CHC-MCO contracts, which is in accordance with federal regulations found in 42 CFR Section 438, Subpart D. Appendix C refers to Section III of the Quality Strategy Toolkit Checklist and lists these state standards.

c. Mechanisms

As required by CFR § 438.204(b)(3), BCIS will regularly monitor and evaluate CHC-MCOs compliance with the contract standards. See the Quality Strategy Toolkit Checklist for a listing of standards, the related contract language, and SMART standards. BCIS will monitor CHC-MCOs based on stipulations in the agreements that require CHC-MCOs to maintain systems that document implementation of the written quality management program description. The CHC-MCO must also develop and implement monitoring mechanisms that include but are not limited to:

1. An annual program description that documents the CHC-MCO’s monitoring strategy across all services, all treatment modalities, and all sub-populations.
2. An annual program evaluation that details all quality management program activities including, but not limited to: studies and activities undertaken; including the rationale, methodology, and results; subsequent improvement actions; and aggregate clinical and financial analysis of encounter data, HEDIS®, CAHPS, CMS adult core and nursing facility measures, Pennsylvania performance measures, and other data requested by DHS.
3. A work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all quality management activities, including, but not limited to:
   a. Data collection and analysis.
   b. Evaluation and reporting of findings.
   c. Implementation of improvement actions where applicable.
   d. Individual accountability for each activity.
   e. Reporting.

d. Participant Satisfaction and Experience

OLTL will contractually require that CHC-MCOs conduct participant satisfaction surveys on at least an annual basis. This includes the collection of annual participant satisfaction data through application of the CAHPS instrument. The CHC-MCOs must contract with independent CAHPS survey organizations accredited by the NCQA to administer the survey. The CAHPS survey organizations will administer the survey annually to a statistically valid random sample of clients enrolled in the CHC at the time of the survey. The standardized survey tool will include questions designed to assess specific dimensions of client satisfaction with providers, services, delivery, and quality, including but not limited to:
1. Overall satisfaction with CHC-MCO services, delivery, and quality.
2. Participant satisfaction with the accessibility and availability of services.
3. Participant satisfaction with quality of care offered by the CHC-MCO’s providers.

In addition, OLTL will require CHC-MCOs to also implement the new HCBS CAHPS survey, which is the experience of care survey originally developed by CMS-funded Testing Experience and Functional Assessment Tools (TEFT) initiative. It will measure participant experience with Medicaid home and community-based services and supports.

e. Provider Satisfaction Survey

BCIS will ensure that the CHC-MCOs conduct annual provider satisfaction surveys. Provider responses to the survey questions assist the CHC-MCOs in identifying areas for improvement and developing action plans. Providers that participate in the survey include PCPs, LTSS providers, specialists, dental providers, hospitals, and providers of ancillary services and any other providers relevant to CHC population. OLTL will require CHC-MCOs to report on provider survey results and actions taken in response to survey results.

f. Grievance and Appeals Logs and Reports

For each of the CHC-MCOs, BQAPA, BCIS, and BPS staff will review grievance and appeals logs and reports on a regular and quarterly basis. The BQAPA will be responsible for reviewing these reports. BQAPA will share findings from this review with the CHC-MCOs, include all OLTL bureaus, and provide this data for CHC-MCO Comparative Reporting and other types of public reports.

g. HEDIS® and Other Performance Measure Results

BQAPA and BCIS will use three formal sources of performance data: HEDIS® and Pennsylvania Performance Measures (PPM). HEDIS® is the most widely used set of clinical performance measures in the managed care industry. OLTL requires that CHC-MCOs submit performance data to provide useful and timely performance comparison information to plans, beneficiaries, and other stakeholders through annual Performance Trending Reports. BQAPA and BCIS will compare plan results to HEDIS® and CAHPS national benchmarks that NCQA calculates using rates reported nationally by Medicaid MCOs. This information will be used by BCIS to develop Community CHC zone-specific Beneficiary Guides that are updated on an annual basis and used by the enrollment assistance contractor to assist participants in their CHC-MCO selection.

h. Consumer Assessment of Healthcare Providers and Systems

The CAHPS surveys ask participants and patients to report on and evaluate their experiences with health care. The Agency for Healthcare Research and Quality provides CAHPS surveys that cover topics that are important to beneficiaries and focus
on aspects of quality that participants are best qualified to assess, such as the communication skills of providers and ease of access to health care services. BCIS will ensure that CHC-MCOs:

1. Conduct both an Adult CAHPS, and once the TEFT HCBS Experience of Care tool is approved by the CAHPS Consortium, use the HCBS CAHPS survey using current versions of the CAHPS survey tools.
2. Include all Medicaid core questions in all surveys.
3. Customize the survey for Pennsylvania by adding the following three dental questions to both the adult CAHPS surveys:
   a. In the last six months, did you get care from a dentist’s office or dental clinic?
   b. In the last six months, how many times did you go to a dentist’s office or dental clinic for care for yourself?
   c. We want to know your rating of your dental care from all dentists and other dental providers in the last six months. How would you rate your dental care (on a scale of 1 to 10)?
4. Submit validated CAHPS results annually on or before June 15 to BCIS.

I. Health Information Technology

Pennsylvania has positioned itself as a leader among state MA programs in the use of electronic health care information to improve the quality and cost-effectiveness of service delivery for MA beneficiaries. OLTL will work closely with OMAP to implement the state’s HIT strategy in order to improve efficiency and coordination of care delivery.

OMAP/OCQI has grant funding available to long-term/post-acute care organizations to link to Health Information Organizations. This connection will improve transitions of care and care coordination among medical facilities.

4. Improvements and Interventions

Once CHC has been implemented, OLTL will work to improve quality of care and services through the identification of processes and tools to improve performance in meeting the Quality Strategy’s objectives. OLTL will determine interventions for quality improvement based on review and analysis of baseline data, results of quality improvement activities, and ongoing assessment of participants’ health care and LTSS needs.

OLTL, OMAP, and OMHSAS will work together to design a strategy on how to focus their respective MCO PIPs on reducing preventable admissions and readmissions. DHS is interested in pursuing special focus studies on the need to better coordinate care management between behavioral health and physical health in order to reduce readmissions of complex beneficiaries, especially those with persistent serious mental illness, multiple chronic physical health conditions, or substance use disorders. In the future OLTL, OMAP, and OMHSAS may consider having an aligned P4P measure
where physical health, behavioral health, and CHC plans are jointly measured to reduce readmissions.

OLTL will identify additional areas for improvements based on analysis of performance measures and other data.

5. Delivery System Reforms

Pennsylvania is currently participating in two critical and important initiatives provided by the Medicaid Innovation Accelerator Program (IAP). Our participation in the Incentivizing Quality and Outcomes (IQO) program will assist the state with strategic planning in developing an IQO approach for CHC. In addition, Pennsylvania is participating in the CMS Medicare-Medicaid Data Integration (MMDI) initiative, which will assist us in addressing the challenge of successfully integrating Medicare and Medicaid data from a variety of sources.

6. Conclusions and Opportunities

Staff in OLTL will take the lead on soliciting input on the Quality Strategy from a number of sources such as the MAAC and its subcommittees. As programmatic changes are implemented, OLTL will evaluate the effectiveness of the Quality Strategy and revise the strategy based upon analysis of outcomes.

Concurrent with the review of the Quality Strategy, DHS will develop its own Quality Work Plan consistent with the overall Quality Strategy and informed by the results of the CHC-MCOs program evaluations and the evaluations of other DHS managed care programs. DHS will incorporate the EQR report in the development of the work plan, and DHS will solicit EQRO input. The work plan will reflect collaborative thinking from program office staff across DHS including but not limited to OMAP, OMHSAS, OLTL, and OIM. Feedback from other sub-committees, governmental agencies, providers, beneficiaries, and advocates may also be reflected as a result of solicitation of public comment and commitment to robust stakeholder engagement to improve program quality. The information received from these sources will help DHS to determine areas of focus for quality activities such as quality improvement measures, improvement projects, and performance indicators.

The DHS senior management team will review and revise the Quality Strategy before finalizing the strategy and submitting it to CMS. This team, with ultimate responsibility for approving and monitoring the Quality Strategy, may also solicit additional feedback and public input. Following DHS’ approval of the Quality Strategy, DHS will discuss any amendments or major revisions to the Quality Strategy with CMS.

In summary, the CHC Quality Strategy is a plan that will bring the CHC program to the next level by focusing on quality of life and service improvements and promoting health outcomes, through key components of contract compliance and other monitoring. This comprehensive plan will improve the delivery of quality care and services to CHC.
participants. The quality improvement infrastructure is in place to monitor the access to and quality of care for beneficiaries that will be new to the CHC program because of health care reforms mentioned above. The Quality Strategy provides a framework to communicate DHS’ goals and objectives to the CHC-MCOs and other stakeholders, while focusing on strategies that consider health care and LTSS quality, costs, and timely access to care.
C. Children’s Health Insurance Program (CHIP)

1. Introduction

A. General Information & History

CHIP’s Mission:

CHIP’s mission is to provide access to affordable, comprehensive health insurance coverage for all eligible uninsured children and teens in Pennsylvania who do not qualify for Medicaid benefits.

CHIP is recognized as a national model for children’s health coverage. CHIP provides free or low-cost health insurance to uninsured children and teens who are not eligible for MA. CHIP is available for families whose income is above 133 percent of the federal poverty level (FPL).

CHIP is comprised of three components which cover children up to age 19 with identical, comprehensive benefits, as follows:

- The free component covers children in families with modified adjusted gross income no greater than 208 percent of the Federal Poverty Level (FPL). The free program is funded through a portion of cigarette tax revenue, the state general fund, and Federal Financial Participation (FFP) at the enhanced Medicaid rate. There are no premiums or co-pays associated with the free program.

- The low-cost component of CHIP covers children in families with a modified adjusted gross income of greater than 208 percent but no greater than 314 percent of the FPL. The parent or guardian is required to pay a modest monthly premium on a sliding scale based upon household income, and is responsible for modest co-payments on certain services and prescriptions. The low-cost component is also funded through a portion of the cigarette tax revenue, the state general fund, and FFP at the enhanced Medicaid rate.

- The third component covers uninsured children with a modified adjusted gross income greater than 314 percent of the FPL. The parent or guardian is required to pay the entire monthly premium as negotiated by the state. There are no state funds expended and no federal reimbursement received for children in the full-cost group. In 2016, families pay an average of approximately $216 per child per month for the premium, and slightly higher co-payments are collected for services and prescriptions. Comparable insurance must either be unavailable or unaffordable for a child to qualify.

Following is an overview of CHIP and its divisions that administer CHIP.
Division of Marketing and Outreach:

The marketing and outreach division has a marketing chief who is responsible for educating the public of the existence of the program and its benefits. A standalone web site, www.CHIPcoversPAkids.com, was developed to help disseminate program information and went live on August 19, 2016. The division maintains the web site that is a central repository for information on eligibility, applying and renewing benefits, and health plan contractor resources. The division works with the nine CHIP contractors to ensure that the CHIP brand and program is represented according to state and federal regulations and the standards of the commonwealth. Per law, each year a flyer is distributed to all school districts in the commonwealth notifying parents and guardians of the program. A marketing and outreach budget utilizes paid advertising such as TV, radio, digital, lifestyle, and grassroots marketing efforts. Collateral pieces are developed and available on the web site for download and bulk ordering and include but are not limited to brochures, flyers, posters, buck slips, coloring books, and book marks. CHIP materials, including the web site, are provided in English and Spanish.

Division of Policy and Planning:

The Policy and Planning Division is responsible for directing the analysis, development, and implementation of programmatic policies and procedures. This area oversees the eligibility review process and the Central Eligibility Unit responsible for CHIP eligibility determination processes. The division is responsible for recommending and implementing program policy based on programmatic, legislative, and budgetary requirements. The division issues the eligibility handbook and instructional transmittals, which direct CHIP contractors regarding the determination of eligibility for enrolling persons applying for insurance coverage.

Division of Quality Assurance:

It is the responsibility of the Division of Quality Assurance to ensure that children are enrolled properly, that services being provided by each contractor are consistent with the requirements set forth in the Request for Proposal (RFP), and that funds appropriated for the program are properly expended. Program monitoring is conducted by Quality Assurance staff who work directly with the contractor on operational and programmatic issues. Quality Assurance staff also oversee utilization of services and direct Quality Improvement initiatives as described in the RFP and the CHIP Eligibility Handbook.

Division of Operations Support:

The Operations Support Division is responsible for several different areas within CHIP. The main focus is the monitoring of the computer system that is used to enter data for the determination of eligibility. This system is the CHIP Application Processing System (CAPS). The business analysts in the division are responsible for monitoring the system through communication with the CHIP health insurance contractors and the Central
Eligibility Unit in CHIP to ensure that the system is determining the correct eligibility for children. This division works closely with the division of policy and planning to ensure the correct implementation of policy in the system. The business analysts document system deficiencies and enhancements, and follow the prioritization, development, and testing of these items. The analysts are also responsible in assisting the IT contractor with the development of IT initiatives from business requirements through system testing and approvals.

The division is also responsible for financial transactions for the CHIP health insurance contractors and other vendors. A statistical analyst in the division reviews invoices and authorizes payment, tracks the CHIP budget, tracks various contracts and purchase orders for CHIP vendors, assists the DHS Budget Office with various financial tasks, and reports enrollment numbers and financial data to federal databases. They also generate various reports from the Data Warehouse concerning CHIP enrollments and various other reports.

History

On December 2, 1992, former Governor Robert P. Casey signed into law House Bill 20 (HB 20), better known as the Children's Health Insurance Act. Legislation initially was sponsored by Representative Allen G. Kukovich (D) in the House and Senator Allyson Y. Schwartz (D) in the Senate.

HB 20 created CHIP, a one of a kind program designed to provide insurance coverage to children whose families earn too much to qualify for MA, but who could not afford to purchase private insurance.

In May of 1993, the first children were enrolled in CHIP.

CHIP would later be used as the model for the federal government's SCHIP program. Legislation for the federal CHIP was signed into law August 5, 1997 by former President Bill Clinton.

Pennsylvania’s SCHIP State Plan was submitted in October of 1997 and approved the following May. In the following years, many more milestones were reached, including: establishing a toll-free help line (1-800-986-KIDS), media campaigns, implementing a central data system, CAPS, and going live with the new CHIP web site: [www.chipcoverspakkids.com](http://www.chipcoverspakkids.com).

The first contracts were effectuated with seven insurance companies in the fall of 1999. These companies were: Highmark, Capital BlueCross/PA Blue Shield, BlueCross of Northeastern PA/PA Blue Shield, Independence Blue Cross/PA Blue Shield, Aetna U.S. Healthcare, Three Rivers Health Plan, and AmeriChoice. These same contracts were renewed in 2002. In the fall of 2005, a new contractor, UPMC, was added.
On November 2, 2006, Act 136 of 2006 was signed into law by former Governor Edward Rendell, expanding eligibility for CHIP to 300 percent of FPL with buy-in option above 300 percent. In early 2007, Pennsylvania received approval from the federal government to expand eligibility for CHIP as part of the Cover All Kids initiative, and in March 2007 the new eligibility guidelines were implemented.

In June of 2015, to protect Pennsylvania families enrolled in the CHIP full cost plan after the federal government had determined that the plan did not meet minimum essential coverage (MEC), Governor Tom Wolf and his administration ensured that the full cost plan did officially meet MEC requirements of the Affordable Care Act (ACA). Originally, the only plans within CHIP that had met the minimum essential coverage requirements had been the Free and Low Cost Plans. This move by Governor Wolf guaranteed that families in the full cost plan did not face tax penalties for 2015 since the requirements were now being met.

With the ACA, health plans were required to also provide parity between mental health/substance use disorder benefits and medical/surgical benefits. This is required by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

On August 20, 2015, Governor Wolf announced that all CHIP health insurance plans would provide the same enhanced benefits to all components of CHIP including free and low-cost. Originally, only CHIP policies where the families paid the entire cost of the premiums had to meet these enhanced benefit requirements. This decision was made because of the importance that all Pennsylvania children have access to the best health care possible.

Governor Wolf signed a new law effective December 20, 2015, that extended Pennsylvania’s Children’s Health Insurance Program through 2017. As part of the new law, the state administration of CHIP moved from the Insurance Department to the Department of Human Services. There were no changes to CHIP enrollees’ health care benefits.

On May 13, 2016, the U.S. Department of Health and Human Services, Office for Civil Rights issued the final rule implementing Section 1557 of the Patient Protection and Affordable Care Act, entitled “Nondiscrimination in Health Programs and Activities.” Coverage related to gender transition services that otherwise fall within a beneficiary’s scope of covered CHIP benefits (e.g., physician’s services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, etc.) will now be compensable under CHIP, including CHIP Managed Care, when deemed medically necessary and appropriate.
CHIP will continue to be the great program that provides quality health insurance to Pennsylvania kids so that they are covered for routine checkups, prescriptions, hospitalization, dental, eye care, and more.

The current insurance contractors with CHIP are: Aetna, Capital Blue Cross, Geisinger Health Plan, Highmark, Health Plan Partners, Independence Blue Cross, Blue Cross North Eastern PA, United Health Care, and the University of Pittsburgh Medical Center.

Blue Cross North Eastern PA (NEPA) and Highmark merged on December 1, 2016.

**B. Managed Care Goals and Objectives**

As part of the Balanced Budget Act of 1997, the United States Congress created Title XXI, CHIP, to address the growing problem of children without health insurance. SCHIP was designed as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. In 1998, the state legislature repealed the existing Children’s Health Care Act and enacted Act 1998-68 to establish the current CHIP. On April 16, 2015, former President Barack Obama signed into law H.R.2: Medicare Access and CHIP Reauthorization Act of 2015 which reauthorized and finances CHIP through fiscal year 2017.

CHIP provides services to enrolled children through a managed care model. By state law and regulation, all of the CHIP contractor delivery systems are state-licensed, managed care organizations (predominantly HMOs, though one of them uses gatekeeper PPO delivery systems in limited counties). Under Pennsylvania statute, these entities are subject to oversight and regulation by the Department of Health and the Insurance Department, which also have joint licensing authority of these entities (see 40 P.S. 1551, et seq. and 31 Pa. Code, Chapters 301-303). The Insurance Department is primarily responsible for monitoring initial capitalization and financial solvency. The Department of Health is charged with monitoring quality of care and assuring the availability of and accessibility to health services.

Goals of CHIP’s Managed Care Program are identified in CHIP’s State Plan (Section 2107(a) (3)) (42 CFR § 457.710(c)). These goals are quantifiable performance driven objectives. They are as follows:

- Increase by 2 percent per year the combined enrollment in CHIP and Medicaid over the base month in which the Pennsylvania state plan was first approved, May 1998.
- Continue to implement initiatives which improve access to coverage (increased use of FQHCs, insurance contractors include Certified Registered Nurse Practitioners and Physician Assistants in provider networks, increase number of practices with after-hours appointments, and the like).
- Increase enrollment in rural counties by at least 5 percent each of the next three years.
• Maintain the proportion of CHIP enrollees to reflect the general population of Pennsylvania.
• Reduce the unnecessary overutilization of ambulatory care and emergency department visits by 2.2 percent each of the next three years.
• Increase frequency of adolescent well-care visits by 3 percent per year for the next three years.
• Increase the percentage of eligible children receiving all vaccinations in HEDIS® combination 2 by 0.7 percent per year for the next three years.

C. Overview of CHIP Contractors

As a condition of their licensure with CHIP, contractors must undergo periodic external reviews of their quality assurance systems and the quality of care provided to their members. These reviews are required within one year of licensure and again at three-year intervals or for cause. The reviews are performed by the National Committee for Quality Assurance (NCQA) with Health Department participation. The scope of review includes a detailed examination of the plan’s quality assurance/improvement program including access, availability, continuity of care, and preventive and health maintenance services to members, including CHIP-enrolled children. NCQA staff independently assesses managed care compliance with current state regulations on a periodic basis. DHS independently identifies opportunities for improvement for CHIP and institutes quality improvement performance measures via its contracted EQRO, as appropriate.

CHIP, in an effort to be consistent with their contractors, developed the Eligibility Handbook and the Procedures Manual. The purpose of these documents is to provide contractors with comprehensive documents that will provide guidance on how to implement the statutory requirements established in Title XXI of the Social Security Act and the Children’s Health Care Act (40 P.S. §§ 991.2301-.2361). The Eligibility Handbook and the Procedures Manual establish standardized procedures and processes to ensure continuity among contractors participating in CHIP.

Contractors are secured through the commonwealth’s procurement process and are managed by all CHIP divisions through the life of the contract. Both state and federal law require that DHS conduct monitoring and oversight of contractors.

Each contractor, at its own expense, is required to make all records available for audit, review, or evaluation by the commonwealth and/or its designated representatives. Access shall be provided as directed by DHS. During the contract and record retention period, these records shall be available at each contractor’s chosen location, subject to approval of the commonwealth. Each contractor must fully cooperate with any and all reviews and/or audits by the commonwealth and its designated representatives, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail must be sent in the form of accurate, legible paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.
Reports requested by DHS for the contractors assist in making the contractors responsive to CHIP members and services feedback. This responsiveness has created a comprehensive system to meet CHIP membership service needs.

Contractors must submit a CAP, as determined by DHS and within timeframes established by DHS, to resolve any performance or quality of care deficiencies identified either by an independent assessor and/or by DHS.

Contractors are also required to report CHIP-specific data for measures based on the latest version of HEDIS®. Measures may change from year-to-year. DHS will notify contractors annually, by official transmittal, of any changes to measures or permissible rotations. All contractors will follow HEDIS® Medicaid product line technical specifications, including Medicaid continuous enrollment requirements per NCQA specifications.

Contractors are required to have HEDIS® results audited by an NCQA licensed compliance vendor. The EQRO collects and analyzes data from each contractor which is related to access to care, utilization of services, and effectiveness of care. The EQRO is tasked with validating the data, collating the data, and making comparisons of the performance of the MCOs. The EQRO then prepares annual HEDIS® reports, along with the Performance Measures and CAHPS reports. The MCO performance is summarized in graph form in the annual Report Card and reported in three categories: access, timeliness, and quality of care. The EQRO is also responsible for developing an official report and report card which is publicly reported.

Accreditation reports are required to be submitted by contractors in addition to accompanying summary score sheets and certificates of accreditation issued by NCQA or other EQRO approved by DOH.

A report should be submitted when operational or structured changes occur within the contractor’s company; if there are changes in the contractor’s personnel, benefit services, or service area; or contractors have marketing/outreach materials that are to be submitted for approval. This report should be submitted when changes occur. Changes imposed by DHS or state/federal mandates need not be reported on this form.

To address 42 CFR § 457.80(b), current state child health insurance coverage and coordination, a state plan must include a description of current state efforts to provide or obtain creditable health coverage for uncovered children, including the steps the state is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships.

Per the requirement of Section 2102(a) (2) 2.2.1., the state must take steps to identify and enroll all uncovered children who are eligible to participate in public health insurance programs. CHIP is committed to providing access to quality health care coverage and to improving the health status of children. Of particular concern are
children of low-income families, families with limited access to care, and families having children with special needs due to chronic or disabling conditions.

To achieve the goal of providing access to health care, the commonwealth has brought together a unique consortium of public agencies, as well as public advocates from the statewide advocacy community dedicated to increasing awareness and enrollment in both CHIP and Medicaid. CHIP advocates meet quarterly.

In addition, per (Section 2107(c)) (42 CFR § 457.120(a) and (b)), the state must have a process to accomplish involvement of the public in the design and implementation of the plan and method for insuring ongoing public involvement. To fulfill this, the commonwealth has conducted public forum hearings across the state to provide a platform for advocacy and community-based groups, private citizens, and representatives of the insurance industry, to express concerns and recommendations on the design and implementation of the state plan.

D. Development and Review of Quality Strategy

When the Pennsylvania Quality Strategy for DHS is finalized, the document will begin a public comment review period. The document will also be sent to the CHIP advisory council (CAC) and be posted on the DHS web site for public review and comment.

The CAC was established within the Insurance Department as an advisory council by Act 68 of 1998, Article XXIII of the Children’s Health Care under Section 2311 (i). Advisory council meetings take place quarterly, with Act 136 mandating the council must meet at least twice a year.

The council consists of 14 voting members. The purpose of the CAC is to provide advice regarding the outreach and enrollment activities of CHIP. Participants review and are asked for their thoughts on membership updates, marketing initiatives, and other program information.

The CAC includes representatives from governmental agencies, participating insurance companies and provider groups as well as beneficiaries. Most CAC members serve for three-year terms, and members may be reappointed for a second three-year term. Officers of the CAC, such as vice president, are elected annually by the members of the CAC. All meetings of the council are conducted pursuant to the act of July 3, 1986 (P.L.388, No. 84), known as the Sunshine Act.

Comments received from the CAC will be examined and help provide the basis for further updates in the Pennsylvania Quality Strategy.

To provide an opportunity for other stakeholders to offer their feedback on the Pennsylvania Quality Strategy, DHS will publish the draft Quality Strategy on its web site at least once every three years.
Each year, the office of CHIP will review program goals used to assess quality planning and strategy success and provide any necessary updates to upper management staff. A two-week internal review process will be undertaken. If modification or updating of the strategy is needed due to "significant changes" (change in federal or state statutory requirements that affect the program), these will be addressed with DHS executive level staff.

2. Assessment

A. Quality and Assessment of Care

Under CHIP, the contractors are held to standards to ensure that all members receive quality and appropriate care. For this to be assessed, there are requirements built into the contracts for state services.

The contractors extend the quality of care to members through various means. Welcome calls for new members are provided by many of the contractors, as well as new member surveys. During new member calls, a health risk assessment is often conducted as well. Member education and outreach are provided by contractor-specific newsletters that include information on important health topics and anything specific to their CHIP coverage. Many newsletters include information on fit and health-issue specific programs (i.e. asthma, diabetes, depression). Other CHIP contractors have community outreach teams that distribute health and wellness materials at community events.

Case Management and Integrated Care Management programs are also provided for members with complex or catastrophic health issues, many of which include face-to-face visits to assist with disease management. Members are assisted through ongoing assessment, care planning, and monitoring. There is also access to health coaches, and outreach by nurses as conditions are identified.

Clinical Quality Committees, which are comprised of staff and board-certified practitioners, develop and adapt clinical practice guidelines. A few of the CHIP contractors also have Family Consumer Advisory Committees.

B. Mechanisms and Eligibility Processes

The CHIP application process begins when a parent submits an application for CHIP benefits on behalf of a child. Applications may be submitted electronically through COMPASS (www.compass.pa.gov), through a telephone call, or in paper form. Applications may also be sent to a contractor as referrals from the CAO. The contractor must process the application to the point that the application can be moved to "pending check" in CAPS within 15 calendar days of the receipt of an application.

When a contractor receives a CHIP application or renewal, the contractor must data enter all information that appears on the application. Mandatory data elements that are
needed for all household members are: Last Name, First Name, Date of Birth, Gender, and Citizenship. The application process screens demographics and assigns a PCP that is within the selected network and also looks for qualifying factors.

If an individual indicates that they have wages, and the wages have been verified, the name of the employer is a mandatory data field in CAPS.

C. Procedures for Race, Ethnicity, Primary Language, and Special Needs

CHIP insurance company contractors are mandated by contract to conduct outreach activities that include canvassing local businesses, daycare centers, school districts, CAOs, hospitals/providers, legislative offices, religious organizations and churches, social service agencies, unions and civic groups, and numerous other organizations and groups.

Each CHIP contractor is required to provide the following outreach information: identification of outreach objectives and activities for the contract period, description of activities to locate potentially eligible children, requirement that outreach materials be linguistically and culturally appropriate, and that outreach services include specific provisions for reaching special populations, and indication of whether the contractor will employ a dedicated marketing staff, and if not, submission of a program to assure special efforts are coordinated within overall outreach activities.

Contractors and providers must demonstrate consistency in providing quality care across a variety of races, ethnicities, and cultures. All contractors employ bilingual representatives who are capable of responding to CHIP inquiries in either English or Spanish. TDD lines allow for communication with the hearing impaired and access to multiple language translating services are also available. Information is also available in alternate format for those with sensory disabilities.

CHIP may gather information on members that includes a wide range of indicators, including pregnancy and if a special need is identified. CHIP follows the Social Security Administration in their definition of a disability for a child:

A physical or mental condition or a combination of conditions, that results in “marked and severe functional limitations.” This means that the condition(s) must very seriously limit the child’s activities. The child’s condition(s) must be permanent or have lasted or be expected to last at least 12 months; or must be expected to result in death.

CHIP contractors are required to review history from medical claims management information to identify children enrolled in CHIP who may potentially be eligible for MA based on the child’s disability. All PH-95 Referrals will be tracked in CAPS by the contractor.
D. **Procedures for Data Collection**

Contractors with CHIP must submit HEDIS® data to DHS annually. The previous calendar year is the standard measurement year for each year’s HEDIS® data. Contractors are required to report CHIP-specific data. DHS will notify contractors annually, by official transmittal, of any changes to measures or permissible rotations. All contractors will follow HEDIS® Medicaid product line technical specifications, including Medicaid continuous enrollment requirements per NCQA’s specifications.

It is important for CHIP contractors to refer to the most recent HEDIS® transmittal to determine the most current measures CHIP is requiring contractors to collect. Contractors are required to submit their data through NCQA’s Interactive Data Submission System’s (IDSS) web-based tool.

E. **Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**

Each CHIP contractor is strongly encouraged to include FQHCs and RHCs in provider networks or as a source of primary care. If the contractor’s primary care network includes FQHCs or RHCs, these sites may be designated as PCP sites.

CHIP contractors are responsible for the reimbursement for an encounter of CHIP-covered services for a CHIP-covered child at a FQHC or RHC at the MA prospective payment rate unless and until federal law allows otherwise.

F. **CHIP Performance Objectives**

The main objectives of CHIP are:

**Objective 1: To ensure that all CHIP-covered children have access to primary and preventive care through a PCP, as well as providing a benefit package that covers access to medically necessary health care through an MCO’s coordinated network of specialists, facilities, and other health care providers, including behavioral health providers** - The commonwealth is committed to providing access to quality health care coverage and to improving the health status of its children. Of particular concern are children of low-income families, families with limited access to care, and families having children with special needs due to chronic or disabling conditions. (Special needs programs include spina bifida, diabetes, asthma, hepatitis B, etc.) To achieve the goal of providing access to health care, the commonwealth has brought together a unique consortium of public agencies, as well as public advocates from the statewide advocacy community dedicated to increasing awareness and enrollment in both CHIP and Medicaid. Three commonwealth agencies (Insurance, Human Services, and Health) jointly committed funding to a multi-media and multi-faceted public awareness campaign for CHIP, Medicaid, and Maternal and Child Health services. The interagency consortium increased awareness and enrollment with the following efforts, which included but were not limited to: establishing a single statewide
Objective 2: To improve the quality of services and health outcomes for CHIP-covered children by proactively managing and regularly measuring the care received using nationally accepted standards and benchmarks - DHS independently identifies opportunities for improvement for CHIP and institutes quality improvement performance measures via its contracted external quality review organization, as appropriate. Quality is also assessed by measuring and monitoring HEDIS®, CAHPS, and additional Pennsylvania Performance Measures. Contractors are required to complete a CHIP-specific CAHPS Survey (CPC). All contractors will follow NCQA’s Specifications for Survey Measures “General Guidelines for Data Collection and Reporting” chapter using the Medicaid product line specifications except for additional questions added to the survey for the purposes of evaluating Pennsylvania CHIP. Contractors must contract with a certified vendor to administer the CAHPS survey.

Additional Pennsylvania-specific Performance Measures will be implemented for the CHIP population, as appropriate to the population’s age range. In 2015, PA CHIP implemented Pennsylvania-specific performance measures, as appropriate to the population’s age range.

- Annual Number of Asthma Patients with An Asthma Related ER Visit (ASMER).
- Total Eligible Who Receive Dental Treatment and Preventive Dental Services (PDENT).

Additionally there is a Report Card published annually in which CHIP health insurance contractor performance is assessed using the current year’s HEDIS® performance measures, the current year’s CAHPS Survey items, and Pennsylvania-specific performance measures. Results are presented in three sections: Access to Care, Quality of Care, and Satisfaction with Care.

Objective 3: To improve the stability and predictability of CHIP expenses while sustaining quality health outcomes, appropriate benefit levels, and reasonable access to care for CHIP-covered children – A Program Financing for State Plan report is provided for the Cost of the Approved CHIP plan with the 2015 Annual Report to CMS (federal) at the following web site on CHIP’s site:
G. Obstetrical Services

Section 2311 (j) (6) of Act 40 P.S. § 991.2301 requires that each contractor provide a specific benefit package with the scope and duration determined by DHS. Women’s Health Services covers those services described under the Women’s Preventive Services provision of the Affordable Care Act. There are no copayments for preventive services.

Obstetrical Services include prenatal, intrapartum, and postpartum care, including care related to complications of pregnancy and childbirth. A referral is not required when the maternity care is provided by a network obstetrician or gynecologist, certified nurse-midwife, or a PCP. Services provided by a participating hospital or birthing center are covered.

Mothers and infants can remain in the hospital for 48 hours after a normal vaginal delivery or 96 hours after a Cesarean delivery. A shorter stay may be covered if the attending provider (physician, nurse mid-wife, or physician assistant), in consultation with the mother, discharges the mother and infant earlier.

H. CHIPRA Set of Measures

CHIPRA section 402(a) (2), which amends reporting requirements in section 2108 of the Social Security Act, requires Title XXI Programs (i.e., CHIP Medicaid expansion programs, separate child health programs, or a combination of the two) to report CAHPS results to CMS. While Title XXI Programs may select any CAHPS survey to fulfill this requirement, CMS encourages these programs to align with the CAHPS measure in the Children’s Core Set of Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Title XXI Programs submit summary level information from the CAHPS survey to CMS. The measures are rated by timeliness, access, and quality of care.

I. Monitoring and Compliance

The office of CHIP meets regularly with contractors to discuss enrollment issues, federal and state mandated reports, medical services, data warehouse information, corrective action plans, and additional operations issues. A quarterly contractor’s meeting is held with all CHIP contractors to discuss administrative changes, IT transitions, policy changes, and quality assurance requirements. During these contractor meetings best practices are shared and encouragement of health insurers to try innovative outreach programs such as social networking and various member recognitions have been key to PA CHIP’s success. These meetings are collaborative dialogue between CHIP and the contractors. In addition to the quarterly meetings, contractors also must participate in a bi-weekly contractor call with CHIP and their IT maintenance contractor.
In addition, DHS may request contractors to submit ad hoc reports to meet a specific reporting need. These requests may result from federal or state legislative/gubernatorial data calls, requests from other state agencies, or requests from public sector entities.

Each contractor is required to electronically transmit enrollee claims and encounter level data to DHS, including any data gathered through subcontractors, via the data warehouse. DHS has developed unique file formats to communicate the necessary information to satisfy ad hoc reporting and requirements for the CAPS Data Warehouse. File formats for health care claim transactions are mandated by HIPAA Transactions and Code Sets regulations when electronically communicating claim information.

Files provided by contractors are:

1. Institutional File – This file contains the institutional claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Institutional mandated guidelines.

2. Professional File – This file contains the professional claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Professional mandated guidelines.

3. Dental File – This file contains the dental claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Dental mandated guidelines.

J. Operations Monitoring: Division of Quality Assurance (QA)

Areas of specific responsibility in CHIP’s QA Division include, but are not limited to: review and compile monthly, quarterly, and annual reports submitted by contractors, monitoring eligibility and enrollment application processing, including transfers between CHIP and MA, conduct random sample reviews (temporarily on hold during the PERM Eligibility Review Pilot), beneficiary service and enforcement issues, coordination of audits reviews, i.e. contractor A-133 independent single audits, PERM related, and coordination of other audits initiated by federal and state agencies, coordination and implementation of corrective action plans, fraud and abuse detection, on-site monitoring and readiness reviews, participate in ongoing CAPS system development and redesign, compliance with the ACA, HIPAA, and overall contract compliance.

Additional tasks include, but are not limited to: HEDIS®/CAHPS annual reviews, performance improvement projects, provider network issues, oversight of EQRO contract, oversight of Data Warehouse claims and encounter data systems, on-site monitoring and readiness reviews, development and implementation of corrective actions, review and compilation of monthly, quarterly, and annual reports, beneficiary and legislative inquiries and correspondence, and coordination of ad hoc data requests.
K. Payment Error Rate Measurement (PERM)

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA, which was amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) in 2012) requires the heads of federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. The Office of Management and Budget (OMB) identified Medicaid and CHIP as programs at risk for significant improper payments. Improper payments are any payments that have been made in error, including payments that should not have been made, payments that were made in the correct amount, and inappropriate denials of payment or services. As a result, CMS developed the PERM program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. Each PERM cycle reviews Medicaid and CHIP payments made in a federal fiscal year. The estimated error rate is typically reported in November of the year following the end of the fiscal year being reviewed.

L. Contract Monitoring Standards

Staff that are part of CHIP Contract Teams are responsible for monitoring certain contract standards for each active contract. In order to ensure predictably satisfactory results during contract execution, DHS Office of Administration requires a contract monitoring plan to be submitted as a component of any statement of work. This document details how the vendor will be evaluated, complete with metrics, sanctions and Service Level Agreements. The DHS monitor will also require, at standard intervals, a contract monitoring checklist. This is to evaluate both performance of the vendor as well as the effectiveness of the contract itself. This checklist can be tailored to the specific needs of a particular procurement and used as a template at the agreed-upon timeframes during the life of the contract.

M. Utilization Management/Quality Management

Each CHIP contractor’s health plan must comply with all federal Quality Management and Utilization Management program requirements and submit data in formats determined by DHS. DHS, in collaboration with the contractor’s health plan, retains the right to determine and prioritize QM and UM activities and initiatives based on areas of importance to DHS and CMS.
N. Fraud and Abuse Reports

Contractors are required to maintain written policies and procedures for the detection and prevention of fraud and abuse. The contractor and its employees must cooperate fully with centralized oversight agencies responsible for fraud and abuse detection and prosecution activities. Such agencies include, but are not limited to, the Insurance Department, the Governor’s Office of the Budget, Bureau of Audits, the Office of the Auditor General, and CMS.

Section I of the report generally requires contractors to provide:

- Information regarding internal company policies and procedures.
- Organization chart of office responsible for fraud and abuse activity.
- Fraud training and frequency.
- Instances of successful prosecution of either a contractor, subcontractor, provider, member, or employee and subsequent corrective actions.
- Methods of detecting fraud and abuse.
- Process for referral to appropriate law enforcement authorities.
- Provider application content regarding fraud and abuse.
- Toll free number/web site for reporting fraud and abuse for both providers and enrollees.
- Contract language for providers/contractors/subcontractors regarding fraud and abuse.
- Monitoring of contractors/subcontractors.

Section II of the report requires information specific to the number, dollar amounts, and content of fraud and abuse cases referred to law enforcement authorities within the contract year from the standpoint of providers, members, employees, or contractor/subcontractors.

O. CMS Core Performance Measures for Children in CHIP

In addition to the PA-specific performance measures, CHIP also collects CMS core performance measures. Specific measures are included for each year’s Administrative Performance Measures report. These annual performance measures may change as CMS makes changes to the Child Core Set.

For the year 2016, CHIP requested from their contracted EQRO to collect the following measures for children in CHIP:

- Dental sealants for six to nine-year-olds at elevated caries risk (SEAL).
- Number of eligible who received preventive dental services (PDENT).
- Developmental screening in the first three years of life (CHIPRA measure DEV).
- Annual number of asthma patients with one or more asthma related ER visits (ASMER).
• Child and adolescent major depressive disorder: suicide risk assessment (SRA).

These Performance Measures for children in CHIP all promote preventative services:

• SEAL and PDENT promote oral health initiatives and preventative services.
• DEV identifies children who have developmental delays early so that early interventions can be put into place.
• SRA is a preventative service under BH. This measure is important due to suicide being a leading cause of death in adolescents.

ASMER is an acute and chronic conditions preventative service and this measure also assists CHIP with reporting data to DOH.

P. External Quality Review Organization

DHS currently contracts with IPRO, an EQRO based out of New York. IPRO also contracts with Pennsylvania’s MA program and develops similar quality measurement tools for CHIP in order to more fully align both programs.

IPRO’s core products and services include quality measurement and improvement surveys and studies, utilization and DRG management, encounter data validation, quality assurance, and health care process design and measurement activities. Additionally, IPRO is licensed by the National Committee for Quality Assurance to conduct HEDIS® audits.

IPRO’s scope of work for CHIP includes:

• Preparing the HEDIS® reports, including a measure result comparison table with weighted averages for each measure.
  o IPRO will create the annual HEDIS® reports, displaying data and rate comparison tables that will be helpful for ongoing monitoring and performance improvement. The tables will provide MCO and national benchmark comparative information (when available and appropriate).

• Implementing selected Pennsylvania-specific performance measures and preparing Pennsylvania performance measure comparison tables.
  o Selected Pennsylvania-specific performance measures used by DHS or Medicaid managed care members will be implemented for the CHIP population (including HMO and PPO members), as appropriate to the population’s age range.

• Preparing Consumer Assessment of Healthcare Providers and Systems survey results and comparison tables.
IPRO will create annual CAHPS data comparison tables that will provide MCO and national benchmark comparative information (when available and appropriate).

- Developing “report cards” to display HEDIS®, CAHPS, and Pennsylvania performance measure results.
  - IPRO will develop an annual report card similar to DHS’ “A Consumer’s Guide to the HealthChoices Health Plans.” The annual report card will display each MCO’s rates for selected CAHPS survey results, HEDIS® measures, and Pennsylvania performance measures.

- Validating one PIP per MCO per calendar year.
  - IPRO will validate one PIP per calendar year per MCO in the CHIP program. CHIP will request that each MCO develop a project to improve performance in the area of Ambulatory Care- Emergency Department Visits based on the HEDIS® measure. IPRO will use the same validation methodology currently used for the Medicaid MCO PIPs that are based on HEDIS® measures.

- Providing technical assistance in the development of a quality-monitoring program.
  - IPRO will provide technical assistance in the development of a state quality-monitoring program for CHIP to include strategic planning.

The CHIP office is compiling a new IFB for their EQRO. Standards for this bid request are for the EQRO to collect and analyze data which is related to access to care, utilization of services, and effectiveness of care from each contractor. The EQRO is tasked with validating and collating the data and making comparisons of the performance of the MCOs. The EQRO will then prepare annual HEDIS® reports, along with the Performance Measures and CAHPS reports. The MCO performance is summarized in graph form in the annual Report Card and reported in three categories: access, timeliness, and quality of care.

3. State Standards

A. Access Standards

All CHIP contractors must notify DHS of any changes to its provider network that materially affect their ability to make available all services in a timely manner. Each contractor must have procedures to address changes in its network that negatively affect the ability of enrollees to access services. DOH regulations require that a managed care plan must report any probable loss from the network of any general acute care hospital and any primary care provider, whether an individual practice or a group practice, with 2,000 or more assigned enrollees.
Each CHIP contractor must:

- Establish and maintain adequate provider networks as determined by DOH to serve all eligible children, to include, but not be limited to: hospitals, children’s tertiary care hospitals, specialty clinics, trauma centers, facilities for high-risk deliveries and neonates, pediatricians, specialists, physicians, pharmacies, dentists, substance use treatment facilities, emergency transportation services, rehabilitation facilities, home health agencies, certified hospice providers, and durable medical equipment (DME) suppliers in sufficient numbers and geographic dispersions to make available all services in a timely manner.

- Have a contracted and credentialed provider network to meet the needs of its enrolled population in the geographic area in which it is approved to provide services.

- Ensure that its provider network is adequate to provide its enrollees with access to quality enrollee care through participating professionals, in a timely manner, and within a reasonable travel time and distance.

Consider the following in establishing and maintaining its provider network:

- Its anticipated CHIP enrollment.

- The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHIP populations to be serviced by the contractor.

- The number and types, in terms of training, experience, and specialization, of providers required to furnish the contracted CHIP services.

- The number of network providers who are not accepting new CHIP patients.

- The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities.

In addition, as CHIP integrates into DHS, a stronger emphasis to provide data from their contractors concerning the access to health care level that is provided to CHIP members is required. This data must be accurate, clear, and patterns and trends must be accessible.

Currently, CHIP requires annual measure reporting on CMS core performance measures as part of the annual Administrative Performance Measure. Quality is also assessed annually by measuring and monitoring HEDIS®, Consumer Assessment Health Plan Survey (CAHPS), and additional Pennsylvania Performance Measures.

Additionally there is a Report Card published annually in which CHIP health insurance contractor performance is assessed using the current year’s HEDIS® performance
measures, the current year’s CAHPS Survey items, and Pennsylvania specific performance measures. Results are presented in three sections: Access to Care, Quality of Care, and Satisfaction with Care. IPRO will develop an annual report card similar to DHS’ “A Consumer’s Guide to the HealthChoices Health Plans.” These rates will be compared to the statewide average using graphics.

Monthly Transformed Medicaid Statistical Information System (T-MSIS) data is submitted by CHIP contractors that allows discussions on data quality issues and additional data-related issues.

Three HEDIS® measures are reported monthly by the contractors as well. Measures are chosen to align with the CHIP objective to provide quality services which promote good health outcomes through proactively managing health care received by CHIP covered children. Current measures are:

- Dental visits for enrollees age 2 – 19.
- Emergency Department Utilization: ED visits, age < 1- 19, per 100 member months.
- Total Acute inpatient Discharges, ages < 1-19, per 1000 member months.

Performance metric ad-hoc requests are also submitted to the contractors via canvassing to see compliance with services and to analyze that the quality of requested services are being provided adequately.

B. Performance Improvement Projects

PIPs are EQR-mandated projects that address priority issues or service issues of concern for the CHIP population. For 2015, CHIP’s PIP topics aligned with MA’s goals of reducing potentially avoidable admissions and increasing access to pediatric preventive dental services. Contractors are required to conduct a Root Cause Analysis, action plan, and monitoring plan for all measures that are below the CHIP weighted average and/or are trending downwards. These root cause analysis include contractor barriers, actions, and monitoring plans. The specific 2015 PIPs for CHIP contractors were:

1. Lead Screening Rates in CHIP - A policy clarification was written in 2016 to inform the CHIP contractors that blood lead level screening is to be a part of the health screening for CHIP children as set out in the Bright Futures Periodicity Schedule. The CHIP policy aligns with DHS’ MA program policy. According to CHIP policy, all children are to be screened for elevated blood lead levels at ages one and two years, and between the ages of three and six if there is no confirmed prior lead blood test. Testing is to be done by capillary or venous blood draw. Results greater than 5 ug/dl (micrograms per deciliter) require further evaluation and interventions as necessary.
The Lead Screening PIP was initiated in 2013 and was aimed to increase the screening rates for children under two. HEDIS® reports over the past three years showed a general trend toward increasing the number of children screened, though for 2015, several contractors showed a decrease in the rates. In 2015 the performance objectives were reviewed and extended to include an objective for 2018.

The annual PIP updates from the EQRO contractor IPRO looked at barriers to testing and interventions. IPRO identified that interventions need to be more active: 1:1 live contact with providers and families rather than generic mailings, identifying gaps in care, and contacting families early enough to get testing done at the recommended times, making sure providers know how to properly code tests that are done, including testing at well child visits, and assisting families with transportation to testing facilities if it is not available in the primary care physician office.

CHIP has a goal to increase by five percent per year, the percentage of two-year-old members who underwent lead screening prior to their second birthday. To improve upon their performance for the lead screening rates, CHIP contractors have begun to do a lead screening mailer to their members, providing rosters of members that should be screened to their PCPs, offering pay-for-performance incentives, and expanding reimbursement to include point of care lead screening testing.

To further access necessary lead levels data, CHIP has begun the process of working with DOH and DHS to establish a protocol to share certain data regarding lead level test results for managed care beneficiaries. This information will be used to provide follow up and outreach to CHIP beneficiaries regarding detectable and/or elevated lead levels.

2. **Emergency Room Utilization** – Another PIP for the CHIP population is the reduction of emergency department visits. The performance goal is to reduce the unnecessary overutilization of Ambulatory Care, Emergency Department visits by 2.2 percent each of the next three years.

The Emergency Department Utilization and Total Acute Inpatient Discharges measures serve as indicators of the quality of services that CHIP provides its enrollees through primary and preventative care. The need for these services is decreased when parents are educated and children stay healthy through quality primary and preventive care that promotes good health.

C. **State Standards**

In the Managed Care Final Rule, 42 CFR § 457.1240(e) - Managed care quality strategy, the state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in § 438.340 of this chapter. In the regulation § 438.340 - Managed care state quality strategy, each state contracting with an MCO, PIHP, or PAHP as defined in § 438.2 or with a PCCM entity as described in § 438.310(c)(2) must draft and implement a written
quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity. These standards are referenced throughout the Quality Strategy document and were incorporated in the contracts.

D. Mechanisms

CHIP approved contractors must use DHS’ CHIP Application Processing System Internet application system process for application entry, eligibility determination, renewals, reporting, and program monitoring. This is required by CHIP in the awarded contract with insurance providers.

Each contractor must participate in the Department’s quality control, quality assurance, and other quality improvement initiatives. The contractor must also perform quality assurance tasks (including, but not limited to, monitoring quality of care and health outcomes and conducting performance improvement projects).

Each contractor must have a quality control and QM process and plan in place. The QM review process must include all aspects of the eligibility determination process, financial accuracy, and system validation. The QM process must include continuous and routine measurement of work to determine the awarded supplier’s compliance with all contract requirements. The results of the QM process, which must be made available to DHS, will assist the contractors and DHS in measuring the quality of work being performed and facilitate recommendations for operational changes.

1) Overview – contractors must comply with all federal QM and UM program requirements and must submit data in formats to be determined by DHS. DHS, in collaboration with the contractor, retains the right to determine and prioritize QM and UM activities and initiatives based on areas of importance to DHS and CMS.

2) Healthcare Effectiveness Data and Information Set – contractors must submit HEDIS® data to the Department by June 15 of each year, unless otherwise directed. The previous calendar year is the standard measurement year for each year’s HEDIS® data.

3) EQR – on at least an annual basis, each contractor must cooperate fully with any external evaluations and assessments of its performance authorized by DHS and conducted by DHS’ contracted EQRO or other designee. Independent assessments will include, but not be limited to, any independent evaluation required or allowed by federal or state statute or regulation.

4) DHS Oversight – the contractor, its providers, and subcontractors shall make available to DHS, data, clinical, and other records and reports for review of quality of care, access, and utilization issues including, but not limited to, activities related to EQR, HEDIS®, Encounter Data validation, and other related activities. Contractors must submit a plan, in accordance with the timeframes established by DHS, to resolve any performance or quality of care deficiencies identified through ongoing monitoring activities and any independent assessments or evaluations requested by DHS. The contractor must obtain advance written approval from DHS before releasing or sharing data,
correspondence, and/or improvements from DHS regarding the contractor’s internal QM and UM programs with any of the other CHIP contractors or any external entity. The contractor must obtain advance written approval from DHS before participating in or providing letters of support for QM or UM data studies and/or any data related external research projects related to CHIP with any entity.

E. Grievance and Appeals Logs and Reports

CHIP enrollees have access to a complaint and grievance resolution process through their managed care plans. This process is mandated by state law (Act 1998-68) for all managed care organizations and requires members to go through a two-step process at the HMO level, with the second level including one-third member representation in the decision-making process. If the member is still dissatisfied, he or she has the right to appeal the plan’s decision to the DOH (grievances) or to request an eligibility review (ER) to CHIP of the contractor’s decision within 30 days of the termination notice, denial letter, or change in program components. If the member is unhappy with their ERP hearing they have the option of escalating their concern to the Secretary of Human Services. The contractor is required to have a data system in place capable of tracking and trending all complaints and grievances. In addition to assuring that appropriate care is accessible to members, this process also enables DHS to track and identify patterns of inappropriate care or service.

F. HEDIS® and Other Performance Measure Units

In addition to evaluating contractors based on their overall NCQA accreditation ratings, the CHIP program also conducts HEDIS® reviews which compare the CHIP population with the commercial subscribers of the insurer. In addition, the program has been doing direct comparisons of its HEDIS® data with medical assistance programs regionally and nationally. The results from HEDIS® reviews are used to investigate potential problem areas and institute quality improvement activities, as appropriate.

CHIP health insurance company performance is assessed using HEDIS® performance measures, CAHPS 5.0 survey items, and Pennsylvania-specific performance measures. Contractors are required to report CHIP-specific data for measures based on the latest version of HEDIS®. Measures may change from year-to-year. DHS will notify contractors annually, by official transmittal, of any changes to measures or permissible rotations. Contractors are required to have HEDIS® results audited by an NCQA licensed compliance vendor.

G. Consumer Assessment of Healthcare Providers and Systems

Per the State Plan, CHIP requires that the contractors and CHIP work together to implement interventions that will raise the rates of preventative services to conform with established CHIP goals. Such intervention includes: patient information on the availability and necessity of services, parent education, a system of patient reminders,
member satisfaction surveys to detect barriers to accessing care, community-based education, physician education, and immunization registries which follow children across providers and insurance programs.

Contractors are required to complete a CHIP-specific CAHPS Survey. This is the collection of annual member satisfaction data. The standardized survey tool includes questions designed to assess specific dimensions of client satisfaction with providers, services, delivery, and quality, including but not limited to:

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

Assessing patient experiences with health care is an important dimension of the quality of care. The Initial Core Set of children’s health care quality measures for Medicaid and CHIP includes a measure of parents’ experiences with their children’s health care based on the CAHPS Survey.

For the CAHPS survey, all contractors will follow NCQA’s Specifications for Survey Measures “General Guidelines for Data Collection and Reporting” chapter using the Medicaid product line specifications except for additional questions added to the survey for the purposes of evaluating PA CHIP. Additional Child CAHPS Mental Health Questions are:

1. If you were concerned about your child’s mental health, which provider would you be most likely to contact?
2. In the last 12 months, how often did your family get the help you wanted for your child’s mental health from any provider?
3. If your child received service from a professional mental health provider in the last 12 months, how often was it easy to get the counseling or treatment you thought your child needed?

The version of the CAHPS survey used by CHIP is the 5.0H core survey. This is the version included in the Healthcare Effectiveness Data and Information Set and differs from the CAHPS 5.0 maintained by the Agency for Healthcare Research and Quality. Compared with CAHPS 5.0, the CAHPS 5.0H core survey includes six additional questions about health promotion and education, shared decision making, and coordination of care.

H. Transformed Medicaid and Statistical Information System (T-MSIS)

T-MSIS is a data system used by CMS to gather eligibility, enrollment, program, utilization, and claim and expenditure data for CHIP and Medicaid. The collection of data from all states will result in a scalable, responsive, flexible, multi-user, and sustainable platform. The data collection will also allow for multiple database interconnectivity.
Federal and state reports from all states will be consistent and accurate and will eliminate the need for multiple federal reporting requirements. Cost, integrity, or value of the purchased services will be easily defined, and data driven decisions will be able to be made to ensure value in health care services. With T-MSIS, the program can readily determine the cost, integrity, or value of the purchased service.

Eight types of files are sent to CMS each month for T-MSIS:

- Eligibility.
- TPL.
- Claim – In-Patient.
- Claim – Long-term care.
- Provider.
- Managed Care.
- Claim – Prescription.
- Claim – Other.

4. Plan for Improvement and Conclusion

CHIP’s plans for improvement to the quality care and services of their members include incorporating changes in policies and procedures to follow the CMS Managed Care Final Rule released May 6, 2016. Many significant changes allow CHIP to align more with the procedures and resources of MA and also promote a smooth transition of enrollees between the programs.

Measurable improvements of quality care that CHIP will be enacting for HEDIS® measurements include requiring the reporting of: the Human Papillomavirus Vaccine for Female Adolescents (HPV) measure and the Medication Management for People with Asthma (MMA) measure.

For the federal fiscal year of 2015, CHIP had a goal to reduce the number of uninsured children. This goal was to increase the combined enrollment in CHIP and Medicaid relative to the base month approval of the PA State Plan for CHIP in May 1998. The measurable increase goal was two percentage points per year. The number of children enrolled in CHIP and Medicaid has increased by 76 percent by the end of federal fiscal year 2015. This percentage is six percentage points more than the previous year’s increase of 70 percent.

CHIP’s future plans include creating enhancements in the primary system that processes enrollment applications (CAPS) to provide a quality dashboard to allow contractors and the Central Eligibility Unit easier workload tracking with greater accuracy. Additional T-MSIS changes to meet CMS reporting requirements in accord with state privacy laws will also take place.
In conclusion, the office of CHIP’s recent move to DHS allows for a better leverage with IT resources and programs to strengthen the quality strategy procedures that were already in place. CHIP will be better able to align its practices with those of Medicaid with both offices now under the same agency. In addition, senior and management staffs of the Departments of Human Services, Health, and Education are more easily consulted to complete strategic planning and to monitor progress, collaborate, share resources, and to problem solve. The efforts of these meetings and relationships with the additional executive staff have increased awareness and enrollment with the program.

As a new inclusion to the DHS Quality Strategy document, CHIP staff will work with OMAP on evaluating the effectiveness of CHIP’s Quality Strategy and revise the strategy based upon analysis. Using the results of the CHIP Annual Report Card and CHIP HEDIS® Comprehensive Performance Report, CHIP will determine areas of focus for quality activities. The CHIP office will evaluate the effectiveness of the Quality Strategy to determine whether potential changes may be needed.
D. Adult Community Autism Program (ACAP)

iv. Office of Developmental Programs (ODP)

Mission Statement:

The mission of ODP is to support Pennsylvanians with developmental disabilities to achieve greater independence, choice, and opportunity in their lives.

1. Introduction

In 2003, the Pennsylvania Autism Task Force was created to identify and plan to address the challenges of individuals and families living with autism. The task force was composed of over 250 family members, service providers, educators, administrators, and researchers to develop a new system to support individuals living with autism. A number of key themes were identified by the task force, including the lack of community-based services for adults with autism over the age of 21, minimal coordination across the multiple systems that attempted to provide support for individuals with autism, and a service delivery system that was not able to address the diversity of individuals on the autism spectrum.

A recommendation of the task force was the development of a community-based services program to support adults with autism. The recommendation was addressed by the creation of a traditional FFS waiver in July 2008, the Adult Autism Waiver, and by the creation of the ACAP in August 2009. ACAP was the first program in the nation to use a single HCBS provider, KAS, to provide an integrated system of care as a traditional managed care organization. ACAP is authorized by the Social Security Act as a PIHP under the 1915(a) authority. ACAP was designed as an integrated service delivery system to provide physical, behavioral, and community-based services to adults with autism. Participants in ACAP are adults aged 21 years of age or older, financially eligible for MA, possessing a diagnosis of autism, and certified as meeting MA program clinical eligibility for an Intermediate Care Facility (ICF). KAS, a subsidiary of Keystone Human Services, functions as a service provider as well as the MCO. ACAP is approved to serve up to 200 participants in Cumberland, Dauphin, Chester, and Lancaster Counties in Pennsylvania.

The commonwealth oversees ACAP through staff of the Bureau of Autism Services (BAS). BAS staff provides clinical and operational oversight of KAS. This oversight is accomplished through on-site record review, face-to-face participant interviews, incident report monitoring, tracking and trending of quarterly data reports, an annual contract review, and the review and approval of all KAS ACAP marketing materials.
2. Assessment

a. Quality Overview

ACAP was developed to provide home and community-based services in a manner distinct from the traditional FFS waiver modality. This unique model, in which a comprehensive array of services are provided by one service provider, enables KAS to easily adjust to changing circumstances in the life of the ACAP participant and provide services accordingly. This program was envisioned to support families and individuals living with autism in their striving toward greater independence and community integration. All work done by BAS staff in evaluation of an ISP, a participant’s utilization of services, and the progress made in the achieving of each participant’s goals are carefully evaluated for adherence to the goals and vision of the program. A large part of the quality framework involves openness and responsiveness to participant and caregiver concerns about ACAP services. BAS, together with KAS, address any and all issues concerning the quality of life of ACAP participants. The program was developed to enable individuals with autism to live the lives they want in the communities of their choice. BAS staff, using the specialized and considerable education and experience from years of work in the autism community, along with the resources of DHS, stridently advocate for the needs of all ACAP participants to facilitate the achievement of the fullest life possible for each ACAP participant.

BAS operational and clinical staff reviews KAS’ adherence to federal regulations and the ACAP Agreement using the discovery, remediation, and improvement method. This method requires the annual evaluation of compliance with MCO regulations in 42 CFR § 438 using data collected from a variety of sources. This evaluation includes assessment of the quality, timeliness, and accessibility of services covered by the PIHP. Data sources include, but are not limited to, participant interviews, on-site document and electronic file reviews, quarterly, and annual KAS reports. In satisfaction of the KAS Quality Assurance and Improvement plan, KAS submits data via Commonwealth systems on episodes of:

1. Law enforcement involvement.
2. Psychiatric emergency room care.
5. Mental health crisis interventions.

BAS regularly requests reports on ACAP participant employment and reviews increases in:

1. Percentage of participants with jobs or engaging in volunteer work.
2. Number of hours participants work or are engaged in volunteer work.
3. Type of employment.
4. Education.
5. Participants’ independence and social skills.
7. Participants’ quality of life.

b. External Quality Review

The ACAP contractor, KAS, and BAS are working toward compliance with the quality assessment and improvement strategy provisions of the Balanced Budget Act (BBA) of 1997 and regulations at 42 CFR § 438 concerning EQR. These MCO regulations require the performance of three activities by the contractor:

1. Authorized services are delivered in a timely fashion consistent with the assessed needs of the ACAP participant. Appointments scheduled for routine and urgent PCP, behavioral health specialist (BHS), and specialist visits are monitored to ensure they conform to regulatory requirements by BAS operational and clinical staff.
2. The EQRO is required to validate program performance measures for a defined monitoring period (one calendar year). The ACAP Agreement requires demonstration of the following by KAS in support of the performance measures:
   i. Improvement in behavioral stability of ACAP participants as seen in decreased episodes of law enforcement, psychiatric emergency room care, psychiatric inpatient hospitalizations, crisis intervention plan use, and mental health crisis interventions.
   ii. Improvement in access to medical services including initial visits with a PCP within three weeks of enrollment, annual dental exams, improved diabetes management, and annual gynecological exams.
3. The selection and validation of a PIP that was underway during the past 12 months.

ACAP, BAS, and KAS began a formal relationship with the EQRO, IPRO, with a description of the required (and voluntary) activities necessary for IPRO to provide the Quality Technical Report required by CMS in satisfaction of BBA regulations and 42 CFR § 438. BAS operational staff made available to IPRO all tools, processes, and monitoring results used to annually determine KAS compliance with the ACAP agreement and all managed care regulations. These were reviewed in March of 2014 by IPRO. Due to the KAS’ inability, at that time, to report valid and complete data that could be certified by the EQRO, the compliance review was suspended to allow KAS time to improve its capabilities. A follow-up visit was completed in October 2014. During the follow-up onsite, KAS provided updates on their organizational structure, reviewed their implementation of key performance indicator monitoring and reporting, provided a walk through demonstration of updates and modifications to the Total Record system, which were implemented based on IPRO’s recommendations, and reviewed enhancements to the new employee orientation training program. KAS implemented modifications to the data collection and data storage methodology in response to initial onsite findings.

c. Performance Improvement Project

KAS submitted the final PIP report in May 2016 addressing the IPRO findings including: the assessment protocol and process, baselines and outcomes for participants in
employment, community living skills, social/communication skills, and participant survey of employment/volunteer outcomes.

d. Policy/Procedure Comparison

BAS operational staff conducts an ongoing review by comparing KAS' organizational structure, personnel requirements, and other documentation with the relevant sections of § 438.206, § 438.207, § 438.214, and the ACAP Agreement to confirm KAS has the experience and capacity to serve ACAP participants. This monitoring confirms the existence of written policies and procedures for selection and retention of providers and that KAS has a uniform credentialing and re-credentialing policy. BAS operational staff also confirms that the MCO provider selection policies and procedures do not discriminate against providers serving high-risk populations or include providers excluded from federal health care programs.

BAS operational staff evaluates the adequacy of KAS' adherence to commonwealth standards established in the MCO/PIHP contracts during the ACAP participant file review that is part of the compliance monitoring process conducted annually. This process involves review of paper and electronic files located at the home offices of KAS and in their Total Record electronic participant file system. During this review, a minimum ten percent sample of participant files are evaluated for completeness and accuracy to determine compliance with managed care regulations § 438.204, § 438.206, § 438.207, § 438.208, and § 438.210.

An online and paper copy of a catalog of providers is made available to ACAP participants by KAS. Quarterly reports are generated by KAS and reviewed for geographic coverage and provider specialty by BAS operational staff. As part of its annual monitoring, BAS operational staff confirms that:

- Direct access to a women's health specialist is made available when necessary.
- A second opinion from a qualified health care professional from within or outside the KAS network was offered when a participant requested one.
- Services are received in a culturally competent manner.
- A non-network provider was used when one was not available within KAS' network.
- Data is also tabulated on the use of an after-hours call system.
- Medically necessary services are available 24 hours per day, seven days per week.
- Audits of medical and service records including whether KAS has established ongoing mechanisms to evaluate their network providers' compliance with standards for performance quality and for timely access to care and services.

BAS operational staff reviews paper and electronic records located at KAS to ensure that a general physical examination, including a vision test, was completed three months prior to the individual's enrollment in ACAP or approved within three weeks of enrollment and that the exam happens at least annually. BAS operational and clinical
staffs review KAS’ efforts to deliver services in a culturally competent manner to all ACAP participants, and in accordance with accepted medical and behavioral practices and professional standards. BAS operational and clinical staffs further confirm that KAS has maintained policies and procedures to ensure effective communication, input, and interaction among members of the support team assigned to a participant and that this team continuously monitors and takes appropriate corrective actions concerning the participant’s ISP.

BAS operational and clinical staffs confirm that an initial ISP was conducted in accordance with regulatory requirements. These requirements include confirmation that the ISP team consisted of the participant, the participant’s guardian, if the participant has one, and the participant’s family consistent with the participant’s or guardian’s wishes. The ISP team additionally must include a behavior specialist, a supports coordinator, and representatives of other disciplines as appropriate. BAS operational staff confirms that the ISP was developed within 14 days after the applicant met program eligibility.

The clinical team reviews the creation and ongoing revision of the ISP and confirms that it includes a Behavioral Support Plan, a Crisis Intervention Plan, and a Medication Therapeutic Management Plan. The Medication Therapeutic Management Plan is required when the participant is prescribed four or more psychotropic medications. The team confirms that a person-centered planning process was used throughout the ISP process. The ISP must include services with the projected amount, frequency, and duration and include a justification for each service, based on the assessed need of the participant. The ISP must also include goals, objectives, and expected outcomes for the participant. The BAS clinical team compares these records to those maintained by KAS in its electronic records system Total Record.

e. ACAP Services

- Certified registered nurse services
- Intermediate care facility (ICF)
- Non-emergency medical transportation to services covered under the Medical Assistance program
- Nursing facility services
- Optometrists’ services
- Chiropractors’ services
- Audiologist services
- Dentist services
- Health promotion and disease prevention services
- Medical supplies and durable medical equipment
- Prosthetic eyes and other eye appliances
- Hospice services
- Mental health crisis intervention services
- Behavioral support (similar to Behavioral Specialist Services in the Adult Autism Waiver)
- Community transition services
- Crisis intervention services
- Adult day habilitation
- Environmental modification
- Habilitation
- Non-medical transportation
- Personal assistance services
• Outpatient psychiatric clinic services
• Respiratory services
• Targeted case management
• Assistive technology
• Family counseling
• Homemaker/chore services
• Pre-vocational services
• Respite
• Supports coordination

• Residential support (similar to residential habilitation)
• Supported employment
• Visiting nurse
• Additional services determined necessary
• Physical, occupational, vision, mobility, and speech therapies (group and individual)

BAS operational staff determines whether all capitated services are available and can be accessed by participants in a timely manner. Monitoring staff also evaluate each capitated service received by a participant in terms of its geographic location, accessibility, and factors of cultural diversity. ACAP operational staff confirms that each participant was offered a choice of at least two primary care physicians (PCPs) and that the PCP was chosen within 14 days. Data is collected on the number of times a PCP was assigned by KAS, the number of times a request to change a PCP was made, and if a referral to a specialist was warranted. The clinical team confirms that resolution occurred regarding any areas of the ISP about which the ISP team did not agree and was resolved by the behavioral health practitioner in consultation with the KAS medical director.

The clinical team reviews the Behavioral Support Plan to confirm that the plan was developed by a behavioral health practitioner or a behavioral health specialist, was based on a functional behavioral assessment, and sufficiently outlines a guide for use by KAS staff who will interact with the participant on a regular basis. The clinical team confirms that the interactions documented in the plan are intended to:

a. Modify the environment to eliminate potential triggers of problem behaviors.
b. Modify responses to problem behaviors so as to increase appropriate behaviors.
c. Decrease problem behaviors.
d. Increase and improve the participant's adaptive behavior.

The plan should outline whether restraints may be used and, if so, the type, circumstances, and duration under which they may be used. The clinical team confirms the plan's adequacy in regards to any physical problems specific to the participant that requires special attention so as to increase the participant's adaptive behaviors.

A Medication Therapeutic Management Plan will be required and reviewed by the BAS clinical team if four or more psychotropic medications are prescribed or recommended by any ISP team member. The clinical team confirms ongoing medication review by a Doctor of Pharmacy. The plan is monitored and evaluated on a regular basis after each crisis event. The clinical team reviews the Crisis Intervention Plan developed by a behavioral health practitioner or a behavioral health specialist to confirm that it was based on a functional behavioral assessment. This plan will include policies and
procedures that meet clinical standards regarding precursor behaviors, the setting or timing of the implementation of the crisis plan, and follow-up.

BAS operational staff confirms that within five days of an ISP meeting, documentation is submitted to the behavioral health practitioner for authorization of services. BAS operational staff reviews participant records to confirm that services were arranged by a supports coordinator and that consistent application of practice guidelines are used for authorization decisions. Written notice of any ISP decision is sent to the participant. BAS operational staff confirms that written notices provide an explanation of the rationale for the decision and any changes between the authorized ISP and the ISP submitted by the team.

Services are evaluated by the BAS clinical team to ensure they are provided in the most inclusive and least restrictive manner, that the services are medically necessary, and that they help the participant improve his or her social and self-management skills and increase the participant’s participation in community life. The clinical team also confirms that the documentation describing the ISP decision-making process meets regulatory and clinical standards.

BAS operational staff will confirm that participants receive notification of a decision to approve or deny a request for services as well as the KAS decision to authorize a service in an amount, duration, or scope less than the amount specified in the ISP. The notification from KAS must give the ACAP participant an opportunity to agree or disagree with the decision. BAS operational staff reviews participant files to confirm they contain instructions concerning how to file a grievance if a participant disagrees with a KAS decision as well as how to request a DHS Fair Hearing or an expedited review. BAS operational staff confirms that any decision to approve or deny a request for a service change is completed no later than five days after receiving the request by the MCO unless additional information is needed by KAS. If no additional information is needed, the participant file must contain a written notice that the decision was mailed or hand delivered within two business days to the following:

1. Participant or his or her representative.
2. Supports coordinator.
3. Prescribing provider, if the prescribing provider is not a member of the team.

If additional information was needed to make a decision by KAS, BAS operational staff confirms that the request for the information was made within three days of receiving the original request for a change in services. The information requested by KAS must be provided within seven days. If there is documentation from a participant’s provider that the participant’s life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular process, an expedited review process will take place. BAS operational staff confirms that the notification of the decision is communicated, at least verbally, no later than three business days after receiving the request for services unless additional information was needed. If no additional information was needed, a written notice of the decision must be mailed or
hand delivered within two business days to the participant or the participant's representative, as appropriate.

BAS operational staff confirms that the complaint/grievance and Fair Hearing processes are followed through review of KAS documentation of complaints filed, resolved, and pending. BAS operational staff confirms that if a participant used the toll-free number to make a complaint/grievance, or if written complaints/grievances were received from participants or providers, documentation exists that complaints were received by the MCO and assistance was provided throughout the complaint/grievance resolution process. Finally, BAS operational staff confirms that the participant received notification of the decision within 45 days of the initial filing of the complaint/grievance, and that KAS' behavioral or medical health practitioner was consulted if the issue was of a clinical nature.

3. Conclusions and Opportunities

The fact that the ACAP program was the first HCBS program of its kind to support adults living with autism through a managed-care model presented unforeseen requirements for the validation of performance measures and the selection of an appropriate PIP. The foundation of both of these requirements is the availability and reliability of the data collected, stored, and reported by KAS. The work of the PIP initially selected by BAS, KAS, and IPRO centered on participant employment but was initially postponed due to KAS' inability to report complete data. IPRO and BAS conducted onsite reviews of the KAS data collection and reporting systems and KAS' organizational structure in March 2014 and October 2014 to assess the KAS' ability to report valid data to meet the requirements for reporting Performance Measures and PIPs, as well as document the services to health plan members. IPRO identified issues regarding data completeness and staff training for patient facing staff, and provided a set of recommendations to KAS to guide KAS in addressing these issues. KAS' response to the recommendations are as follows and details the work by KAS to harmonize its diverse data reporting and collecting systems to achieve the required level of reporting and validity that began in 2013 and continued through 2014 and 2015.

1. KAS completed a reconciliation of the electronic record system, its other IT systems, and paper participant records.
2. KAS' electronic record system was modified to more inclusively collect medical information about ACAP participants.
3. KAS developed new processes and trained staff to increase the equality of data entered into the electronic record system.
4. KAS developed a quality assurance process for participant data entry.
5. KAS developed a quality assurance process for supplemental participant documentation.
6. KAS developed a process to document all care provided to ACAP participants by providers outside of the MCO.
7. KAS developed a process for improved utilization and review of a participant ISP.
8. KAS has increased staffing levels to increase the integration between physical and behavioral health data and services.
9. KAS has increased staffing levels to provide support, direction, and improvement to its efforts to manage quality and compliance measurement issues.
10. KAS continues to expand and develop training for new and existing staff who will engage directly with ACAP participants and caregivers on the complexities of supporting people with autism.

In October 2014, IPRO returned to KAS to finalize the visit conducted initially in March 2014 to approve the ability of KAS to provide verifiable data for the performance measures selected by the ACAP program and used in any proposed ACAP PIP to further BAS efforts toward increasing service quality. KAS implemented modifications to the data collection and data storage methodology in response to initial onsite findings. KAS also provided an update on staffing changes, modifications to the new employee orientation training program, and discussed organizational training initiatives. KAS has also staffed a Director level quality management position to address the need for oversight of process review, assessing data completeness, and continued quality improvement.

Simultaneous to the CMS mandated quality work involving the EQRO, BAS directed its partner organization, the Autism Services, Education, Resources, and Training (ASERT) Collaborative to work with KAS to conduct a series of focus groups beginning in September 2013 and again in October 2015. ASERT is a statewide initiative funded by BAS and is tasked to support the work of BAS and its programs. The goal of the ACAP focus groups was to provide qualitative data to support and inform program planning and improve communication between participants served by the program, their families, caregivers, KAS, and BAS. ACAP participants, families, and caregivers from the four counties served by ACAP, as well as KAS leadership, supports coordinators, behavioral health specialists, and community support professionals participated in the focus group sessions.

The ASERT team analyzed the responses of the focus group participants and produced a report containing key issues related to ACAP service quality. These findings and KAS' responses are being presented to members of the autism community as well as the families and individuals who originally participated in the focus groups by ASERT and KAS during follow-up meetings. The findings to which KAS responded included staffing issues, training needs, family/caregiver understanding of aspects of the ACAP program different from the behavioral support systems families were familiar with, as well as the need for enhanced community engagement opportunities for ACAP participants. KAS responses to these findings will impact the monitoring done by BAS operational staff beginning in 2014 and thereafter. BAS operational staff continues to modify the ACAP monitoring tools and processes in order to assess KAS accountability in achieving the improvements promised. Following the focus groups conducted in 2015, ASERT produced a report highlighting themes that were recurring from the previous focus groups and themes that had newly emerged. The key themes included in the 2015 focus group report included: staff training, communication between KAS leadership and
KAS staff and between KAS and the program participants and their families, community engagement and socialization, and topics related to employment. BAS and ASERT will engage in continued monitoring of KAS in relation to the findings of both focus group efforts.

The goals for the ACAP program have not wavered from those framed by the Autism Task Force and focus on greater independence and community integration for people living with autism. From the confounding influences of a mental health diagnosis and a substance abuse disorder on the provision of supports for someone with autism, to the challenges presented to a family system of a previously dependent adult’s increasing independence, both KAS and BAS have grown in learning what prevents full achievement of what was envisioned for the program. A number of proposals are under consideration to address these challenges. KAS has added a full-time associate clinical director for families to support families with the ongoing transition that occurs in the family system as the ACAP participant moves toward greater levels of independence. This staff person also supports the evolving service needs of the ACAP participant, provides ongoing guidance to direct support staff, as well as assist with management of HCBS programmatic requirements which often confuse participants and caregivers alike.

BAS is further interested in achieving new benchmarks for closer aligning with participant goals and program outcomes. Another interest of BAS is a resolution to the increasingly difficult issue of housing and the role of Adult Protective Service protections among ACAP participants. Achieving these goals is prerequisite to any increase in the program beyond its current four-county limit and will enable BAS to respond to the dramatic increase in adults with autism expected in Pennsylvania. BAS is fully engaged in a collaborative relationship with KAS to realize the ACAP vision and plans to use all tools at its disposal including the ASERT-led focus group findings, analysis of participant and caregiver feedback, and participant data from the MCO’s to evaluate program quality and participant success as well as achieve compliance with quality standards as set forth in the Managed Care Final Rule 42 CFR 438, Subparts D and E. Finally, BAS remains eager to collaborate with DHS’ behavioral and physical health systems to achieve the lives desired by ACAP participants.
Appendix A: HealthChoices Quality Measures – The Core Set of Children’s Health Care Quality Measures (Child Core Set)\(^6\)

**HEDIS® Measures:**

1. Measure HPV-CH: Human Papillomavirus (HPV) Vaccine for Female Adolescents
2. Measure WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents
3. Measure CAP-CH: Children and Adolescent Access to Primary Care Practitioners
4. Measures CIS-CH: Childhood Immunization Status
5. Measure IMA-CH: Immunization Status for Adolescents
6. Measure FPC-CH: Frequency of Ongoing Prenatal Care
7. Measure PPC-CH: Timeliness of Prenatal Care
8. Measure W15-CH: Well-Child Visits in the First 15 Months of Life
9. Measure W34-CH: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
10. Measure AWC-CH: Adolescent Well-Care Visit
11. Measure CHL-CH: Chlamydia Screening in Women
12. Measure MMA-CH: Medication Management for People with Asthma
13. Measure AMB-CH: Ambulatory Care – Emergency Department Visits
14. Measure CPC-CH: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H, Medicaid Children **without** Chronic Conditions

**Non-HEDIS® Measures:**

1. Measure LBW-CH: Live Births Weighing less than 2,500 Grams *(First year reported was 2012 for CY 2011 data)*
2. Measure PC-02: PC-02 Cesarean Section for Nulliparous Singleton Vertex (NSV) *(First year reported was 2012 for CY 2011 data)*
3. Measure DEV-CH: Developmental Screening in the First Three Years of Life *(First year reported was 2013 for CY 2012 data; measure suspended for reporting in 2014 due to code validity issues)*

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\(^6\) Measures listed as published from CMS July 2014 Child Core Set Manual. As new updates are published, revisions will be made to Appendix A as needed.
4. Measure PDENT-CH: Percentage of Eligibles who Received Preventive Dental Services *(First year reported was 2012 for CY 2011 data; CMS uses states’ submitted CMS 416 to develop rates per 2012 or 2013 webinar)*

5. Measure TDENT-CH: Percentage of Eligible who Received Dental Treatment Services *(First year reported was 2012 for CY 2011 data; CMS uses states’ submitted CMS 416 to develop rates per 2012 or 2013 webinar)*

6. Measure ADD-CH: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (AHDH) Medication *(HEDIS® measure enhanced with BH data; first year reported was 2013 for CY 2012 data)*

**Behavioral Health HEDIS® Measures (reported by OMHSAS):**

1. Measure FUH-CH: Follow-Up After Hospitalization for Mental Illness

**Measures Not Yet Reported:**

1. Measure BHRA-CH: Maternity Care, Behavioral Health Risk Assessment *(Possibly reporting in 2015 for CY 2014 data)*

2. Measure CLABSI-CH: Pediatric Central Line-Associated Blood Stream Infections *(Currently no plans to report)*
The Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set)\textsuperscript{7}

**HEDIS\textsuperscript{®} Measures:**

1. Measure FVA-AD: Flu Vaccinations for Adults, Ages 18-64 (part of CAHPS 5.0H Adult Survey)
2. Measure ABA-AD: Adult Body Mass Index Assessment
3. Measure BCS-AD: Breast Cancer Screening
4. Measure CCS-AD: Cervical Cancer Screening
5. Measure MSC-AD: Medical Assistance with Smoking and Tobacco Use (part of CAHPS 5.0H Adult Survey)
6. Measure CHL-AD: Chlamydia Screening in Women Ages 21-64
7. Measure CBP-AD: Controlling High Blood Pressure
8. Measure LDL-AD: Comprehensive Diabetes Care: LDL-C Screening (measure will be deleted as of HEDIS\textsuperscript{®} 2015 per NCQA Technical Specifications, Volume 2)
9. Measure HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Testing
10. Measure AMM-AD: Antidepressant Medication Management
11. Measure SAA-AD: Adherence to Antipsychotics for Individuals with Schizophrenia (HEDIS\textsuperscript{®} measure enhanced with BH data; first year reporting will be 2014 for CY 2013 data)
12. Measure MPM-AD: Annual Monitoring for Patients on Persistent Medications
13. Measure PPC-AD: Postpartum Care

**Non-HEDIS\textsuperscript{®} Measures:**

1. Measure PCR-AD: Plan All-Cause Readmission (Pennsylvania does not use the HEDIS\textsuperscript{®} measure but a Pennsylvania Performance Measure with variations in the specifications)
2. Measure PQI01-AD: PQI 01 Diabetes Short-Term Complications Admission Rate
3. Measure PQI05-AD: PQI 05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
4. Measure PQI08-AD: PQI 08 Heart Failure Admission Rate
5. Measure PQI15-AD: PQI 15 Asthma in Younger Adults Admission Rate

\textsuperscript{7} Measures listed as published from CMS May 2014 Adult Core Set Manual. As new updates are published, revisions will be made to Appendix A as needed.
Behavioral Health HEDIS® Measures (reported by OMHSAS):

1. Measure FUH-CH: Follow-Up After Hospitalization for Mental Illness
2. Measure IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measures Not Yet Reported:

1. Measure PC01-AD: PC-01 Elective Delivery (*EQRO developing and producing rates for CY 2013 as a pilot measure*)
2. Measure PC03-AD: PC-03 Antenatal Steroids
3. Measure HVL-AD: HIV Viral Load Suppression
4. Measure CRT-AD: Care Transition – Timely Transmission of Transition Record
### Appendix B: PH-MCO Operations Reports

<table>
<thead>
<tr>
<th>Report Number</th>
<th>Report Name</th>
<th>Submitted for</th>
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<tbody>
<tr>
<td>OPS 1 - ANNUAL</td>
<td>Organization Chart</td>
<td>Entire Plan</td>
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<tr>
<td>OPS 2 - QUARTERLY</td>
<td>Member Hotline Summary Statistics</td>
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<tr>
<td>OPS 3 - QUARTERLY</td>
<td>DOH Complaints and Grievances Report</td>
<td>Entire Plan</td>
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<td>OPS 4 - QUARTERLY</td>
<td>Member Complaints and Grievances Summaries / Total Expedited Member Grievances</td>
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<td>OPS 5 – QUARTERLY</td>
<td>Provider Network Annual Report with Quarterly Updates of Deletions and Additions</td>
<td>Entire Plan</td>
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<tr>
<td>OPS 6 – ANNUAL with As Needed Updates</td>
<td>Subcontractor Identification</td>
<td>Entire Plan</td>
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<tr>
<td>OPS 7 - QUARTERLY</td>
<td>LEP/Alternative Formats and Training</td>
<td>Entire Plan</td>
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<td>OPS 8 – QUARTERLY</td>
<td>MCO Shift Care Report</td>
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<td>OPS 9 - ANNUAL</td>
<td>Consumer Incentives</td>
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<td>OPS 10 - MONTHLY</td>
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<td>OPS 11 - QUARTERLY</td>
<td>Provider Education</td>
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<td>OPS 12 – BI-ANNUAL</td>
<td>Medically Fragile Transition Report</td>
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<tr>
<td>OPS 13 - QUARTERLY</td>
<td>PA 1540 - Contractor Partnership Program Employment Report</td>
<td>By Zone</td>
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<td>OPS 14 - QUARTERLY</td>
<td>Disadvantaged Business Utilization</td>
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<td>Enhanced Medical Home and Care Management</td>
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<td>OPS 16-QUARTERLY</td>
<td>Dental and Pharmacy Benefit Limit Exception (BLE) Data Reporting</td>
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<td>OPS 17 –</td>
<td>PH-MCO and BH-MCO Integrated Care Plan (ICP) Program Pay-for-Performance</td>
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<td>OS 18 – BI-ANNUAL</td>
<td>Hepatitis C PH-MCO Management and SVR Tracking Dashboard</td>
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### Quality Management and Utilization Management Reports

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<td>QM/UM Work Plan</td>
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<td>QM/UM3</td>
<td>QM/UM Policy and Procedure Manual</td>
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<td>QM/UM Table of Organization</td>
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<td>QM/UM6</td>
<td>Quarterly QM/UM Work Plan Updates</td>
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<td>QM/UM7</td>
<td>Denial Logs Denial Q&amp;A</td>
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<td>QM/UM 8</td>
<td>Licensed Proprietary Products (Interqual, Milliman, etc.)</td>
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### Appendix C: Quality Strategy Toolkit Reference Crosswalk

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<th>ODP Page Reference or Comment</th>
<th>OLTL Page Reference or Comment</th>
<th>CHIP Page Reference or Comment</th>
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<tr>
<td><strong>SECTION I: INTRODUCTION:</strong> Managed Care Goals, Objectives, and Overview:</td>
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<td></td>
<td>Include an overview of the quality management structure that is in place at the state level. For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.?</td>
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<td>CHIP Chapter Introduction Section</td>
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<td>Include general information about the state’s decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.</td>
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<td>Include a description of the goals and objectives of the state’s managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state’s priorities and areas of concern for the population covered by the</td>
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<td>MCO/PIHP contracts. For example, “the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years” or “through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in enrollee access to primary care”.</td>
<td>§438.202(b) Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.</td>
<td>Quality Strategy Introduction</td>
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<td>§438.202(b) Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.</td>
<td>Quality Strategy Introduction</td>
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APPENDIX E
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<tr>
<td>§438.202(d)</td>
<td>Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of “significant changes,” include the state’s definition of “significant changes.”</td>
<td>Quality Strategy Introduction</td>
<td>Quality Strategy Introduction</td>
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<td>OMHSAS Chapter Introduction</td>
<td>Section</td>
<td>Section</td>
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<tr>
<td>Quality and Appropriateness of Care:</td>
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<td>OMAP Chapter, Assessment Section</td>
<td>OMHSAS Chapter, Assessment Section</td>
<td>ACAP Chapter, Assessment Section</td>
<td>OLTL Chapter Assessment Section</td>
<td>CHIP Chapter Assessment Section</td>
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<tr>
<td>§438.204(b)(1)</td>
<td>Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state’s definition of special health care needs.</td>
<td>Quality Strategy Introduction</td>
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<td>OMHSAS Chapter, Assessment Section</td>
<td>Quality Strategy APPENDIX E</td>
<td>Quality Strategy APPENDIX E</td>
<td>Quality Strategy APPENDIX E</td>
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<tr>
<td>§438.204(b)(2)</td>
<td>Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.</td>
<td>Quality Strategy Introduction</td>
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<td>OMHSAS Chapter, Assessment Section</td>
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<tr>
<td>Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.</td>
<td>Quality Strategy Introduction</td>
<td>Optional Component</td>
<td>Quality Strategy Introduction</td>
<td>Conclusions and Opportunities Section</td>
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<td>ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Section</td>
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<td>National Performance Measures:</td>
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<tr>
<td>§438.204(c)</td>
<td>Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.</td>
<td>Quality Strategy OMAP Chapter, Assessment Section</td>
<td>Quality Strategy OMHSAS Chapter, Assessment Section a. 2</td>
<td>Quality Strategy ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter Assessment Section</td>
<td>Quality Strategy Introduction</td>
</tr>
<tr>
<td></td>
<td>Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.</td>
<td>Quality Strategy OMAP Chapter, Assessment Section</td>
<td>Quality Strategy OMHSAS Chapter, Assessment Section a. 2</td>
<td>Quality Strategy ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter Assessment Section</td>
<td>Quality Strategy Introduction</td>
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**Monitoring and Compliance:**

<p>| §438.204(b)(3) | Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of Subpart D (access, structure, and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: • Member or provider surveys; • HEDIS® results; • Report Cards or profiles; • Required MCO/PIHP reporting of | Quality Strategy OMAP Chapter, Assessment and State Standards Sections | “…regular monitoring.” OMHSAS Chapter, Assessment Section a.1 | Quality Strategy ACAP Chapter, Assessment Section | Quality Strategy OLTL Chapter, Assessment and State Standards Sections | Quality Strategy Introduction |
|                | | | “…mechanisms for monitoring” OMHSAS Chapter, Assessment Section a.1 | | | Pennsylvania’s Title XXI State Plan for the Children’s Health Insurance Program (CHIP) Amendment (SPA) 12, |</p>
<table>
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<th>Description</th>
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<td>performance measures; • Required MCO/PIHP reporting on performance improvement projects; • Grievance/Appeal logs, etc.</td>
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<td>Section 7.1.4 &amp; Section 7.2</td>
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<tr>
<td>External Quality Review (EQR):</td>
<td>§438.204(d) Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time.</td>
<td>Quality Strategy OMAP Chapter, Assessment Section</td>
<td>Quality Strategy OMHSAS Chapter, Assessment Section a.4</td>
<td>Quality Strategy ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter, Assessment Section Community HealthChoices Agreement Exhibit K(2), relating to external quality review Community HealthChoices Agreement Exhibit K(1), Standard III(J), relating to requirements for Performance Improvement Projects Community HealthChoices Agreement Exhibit K(1),</td>
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<td>Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform. The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP; 2. Administration or validation of beneficiary or provider surveys of quality of care; 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; 4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and 5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.</td>
<td>Quality Strategy OMAP Chapter, Assessment Section</td>
<td>Quality Strategy OMHSAS Chapter, Assessment Section a. 3 (a &amp;b), 4</td>
<td>Quality Strategy APPENDIX I</td>
<td>Quality Strategy OLTL Chapter, Assessment Section</td>
<td>Quality Strategy CHIP Chapter State Standards Section</td>
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<tr>
<td>§438.360(b)(4)</td>
<td>If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or PA BH HC does not deem any compliance results based upon</td>
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<tr>
<td>§438.360(c)(4)</td>
<td>If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication option under § 438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2).</td>
<td>N/A</td>
<td>N/A see above explanation</td>
<td>N/A</td>
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**SECTION III: STATE STANDARDS:**

**Access Standards:**

<p>| §438.206 | Availability of Services | Maintains and monitors a network of appropriate providers | HealthChoices Agreement: Section V.F.16. Provider Directories, Section V.S. Provider Network, Section VIII.B.4. Provider Network, Exhibit AAA(1) Provider Network Composition/Service Access | Ref.: HealthChoices Behavioral Health Program-Program Standards and Requirements (PS&amp;R), July 1, 2014; pp. 24-6. Section II-4. B. Coordination of Care 1) h., k., m. x); E. Provider Enrollment Quality Strategy APPENDIX E | ACAP Agreement: Article 2.5 Administration, Section G1, Purchase of Sub-Contract with Providers and Section H 5 d, Provider Selection Article 6.1 Quality Management, Section A 2 and 3. | Community HealthChoices Agreement Section IV(A), relating to Certification, Licensing and Accreditation Community HealthChoices Agreement Exhibit BB, relating to Provider Network Composition/Service Access Community HealthChoices | SPA 12, Section 7.2 PA Code Title 28 Section 9.679 (c)(d)(e)(m) Section 9.681 (d) IFB #6100024102 Section L Version 2/8/13 CHIP Policy 35.2 Provider File |</p>
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<tr>
<td>§438.206(b)(2)</td>
<td>Female enrollees have direct access to a women’s health specialist</td>
<td>HealthChoices Agreement: Section V.A.6. Self-Referral/Direct Access</td>
<td>N/A Specific citation deals with women’s routine and preventive health care services.</td>
<td>ACAP Agreement: Article 2.1 Service Provisions, Functions and Duties of the Contractor, Section R</td>
<td>Community HealthChoices Agreement Section V(A)(6), relating to Self-Referral/Direct Access</td>
<td>Agreement Exhibit BB(1)(j) relating to Qualified Providers</td>
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<tr>
<td>§438.206(b)(3)</td>
<td>Provides for a second opinion from a qualified health care professional</td>
<td>HealthChoices Agreement: Exhibit AAA(1), 1.r Second Opinions</td>
<td>PS&amp;R- p.35; Section C. Member Services/Member Rights, 2) Member orientation Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.1 Service Provisions, Functions and Duties of the Contractor, Section T</td>
<td>Community HealthChoices Exhibit R (41) relating to CHC-MCO Participant Handbook Community HealthChoices Exhibit BB(1)(s) relating to Second Opinions</td>
<td>CHIP Policy Manual Chapter 37 Benefits Package</td>
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<td>§438.206(c)(1)(i)</td>
<td>Providers meet state standards for timely access to care and services</td>
<td>HealthChoices Agreement: Section IV.C. General Laws and Regulations 4. (references compliance with Federal and State law but not timely access) Exhibit AAA(1), 1. Network Composition (references timely access but not state</td>
<td>PS&amp;R p. 19-20, 21: II-4. A. In-Plan services 1), 8). p. 54: F. Service Access Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.5 Administration, Section H 5 D and Article 6.1, Quality Management, Section A 2</td>
<td>Community HealthChoices agreement Section V(BB)(2) and Exhibit BB(1), relating to Provider Network Composition/Service Access CHC Agreement Section IV(D) relating to General Laws and Regulations</td>
<td>PA Code Title 28 Section 9.651 (c) emergency services Section 9.679 (d)(e)(f)(g) IFB #6100024102 Section M (f) Version 2/8/13</td>
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<td>§438.206(c)(1)(ii)</td>
<td>Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service</td>
<td>HealthChoices Agreement: Section V.R. Provider Services (provides minimum required hours - does not reference commercial or Medicaid FFS hours)</td>
<td>PS&amp;R p. 20: II-4, A. 2); p. 53: F. Service Access, 1</td>
<td>Article 2.1 Service Provisions, Functions and Duties of the Contractor, Section I</td>
<td>CHC Agreement Exhibit BB(1)(k) relating to Participant's Freedom and Choice and BB(2)(a) relating to general appointment standards</td>
<td>IFB #6100024102 Section M (e) Version 2/8/13</td>
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<td>§438.206(c)(1)(iii)</td>
<td>Services included in the contract are available 24 hours a day, 7 days a week</td>
<td>HealthChoices Agreement: Section V.S.9 Twenty-Four Hour Coverage, Section V.G.2 PH-MCO Internal Member Dedicated Hotline</td>
<td>PS&amp;R p. 13: II-3., B. 5); p. 22: II-4, A. 8); p. 53: F. Service Access, 1</td>
<td>ACAP Agreement: Article 2.1 Service Provisions, Functions and Duties of the Contractor, Section D and E</td>
<td>CHC Agreement Section V(P)(1), relating to General Participant Services</td>
<td>IFB #6100024102 Section M (e) Version 2/8/13</td>
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<td>§438.206(c)(1)</td>
<td>Mechanisms/monitoring to ensure compliance by providers</td>
<td>HealthChoices Agreement: Exhibit A. Managed Care Regulatory Compliance Guidelines</td>
<td>PS&amp;R Sections I-5. On-Site Reviews (p. 3), I-20. Project Monitoring (p. 8); p. 9: Section II-2. B. 1) b.; p. 17: Section II-3. E. Compliance with Federal &amp; State Laws, Regulations, Department Bulletins and Policy Clarifications; p. 18: F. False Claims and H</td>
<td>ACAP Agreement: Article 2.5, Administration, Section F and G Article 6.1, Quality Management, Section A 2</td>
<td>CHC Agreement Exhibit A, relating to regulatory compliance guidelines</td>
<td>CHIP Policy Manual Chapter 34.1 Chapter 34.2.4 to 34.2.6 CAHPS Survey Chapter 36 Fraud &amp; Abuse Reporting</td>
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<td>§438.206(c)(2)</td>
<td>Culturally competent services to all enrollees</td>
<td>HealthChoices Agreement: Section V.S.2 Cultural Competency</td>
<td>PS&amp;R Section II-5.D.1 b and c. page 48 and e. page 49; Appendix CC</td>
<td>ACAP Agreement: Article 2.1, Service Provisions, Section EE</td>
<td>CHC Agreement Section V(BB)(3), relating to Cultural Competency, Linguistic Competency, and Disability Competency</td>
<td>IFB #6100024102 Section V (1)(2) Version 2/8/13</td>
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<td>§438.207</td>
<td>Assurances of Adequate Capacity and Services</td>
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<td>§438.207(a)</td>
<td>Assurances and documentation of capacity to serve expected enrollment</td>
<td>HealthChoices Agreement: Section V.O.7.m Management Information Systems Section V.S.4 Specialists as PCPs, Exhibit AAA(1), 1.Network Composition</td>
<td>PS&amp;R II-5 D. 1 – page 48</td>
<td>ACAP Agreement: Article 2.1, Service Provisions, Section H Article 4.3 Enrollment, Section A 1</td>
<td>CHC Agreement Exhibit BB(1), relating to Provider Network Composition/ Service Access</td>
<td>IFB #6100024102 Section L (2)(3) Version 2/8/13 SPA 12, Section 7.2.1, 7.2.2</td>
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<td>§438.207(b)(1)</td>
<td>Offer an appropriate range of preventive, primary care, and</td>
<td>HealthChoices Agreement:</td>
<td>PS&amp;R II-4 C.3) page 37</td>
<td>ACAP Agreement: Article 2.1, Service</td>
<td>CHC Agreement Section BB,</td>
<td>IFB #6100024102</td>
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Performance Standards and Damages, 2) Sanctions and Penalties; p. 34: II-4. C. 2) Member Orientation, e. xvii) e); p. 50: II-5. D. 2. j. & k. Also, App. R. Quality Strategy APPENDIX E
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<td>§438.208</td>
<td>Coordination and Continuity of Care</td>
<td>HealthChoices Agreement: Section V.C. Continuity of Care Section V.D. Coordination of Care</td>
<td>PS&amp;R II-4 B Continuity of Care, page 23</td>
<td>ACAP Agreement: Article 2.1, Service Provisions, Section L and AA Article 4.4 Disenrollment, Section B</td>
<td>CHC Agreement Section V(C) relating to Continuity of Care Agreement Sections V(E-H) Relating to Comprehensive Needs Assessments and Reassessments; Person-Centered Planning Team Approach; Person-Centered Service Plans; and Care</td>
<td>PA Code Title 31 Section 154.15 IFB #6100024102 Section M(b) Version 2/8/13</td>
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<td>§438.208(b)(1)</td>
<td>Each enrollee has an ongoing source of primary care appropriate to his or her needs</td>
<td>HealthChoices Agreement: Section V.S.3. Primary Care Practitioner (PCP) Responsibilities</td>
<td>PS&amp;R II-4 B.2 page 27</td>
<td>ACAP Agreement: Article 2.1, Service Provisions, Section J</td>
<td>CHC Agreement Section V(Y) relating to Selection and Assignment of PCPs</td>
<td>PA Code Title 28 Section 9.684 (a)(1)</td>
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<td>Quality Strategy APPENDIX E</td>
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<td>Agreement Section V(BB)(4) relating to Primary Care Practitioners Responsibilities</td>
<td>IFB #6100024102 Section L Version 2/8/13</td>
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<td>§438.208(b)(2)</td>
<td>All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP</td>
<td>HealthChoices Agreement: Section V.D. Coordination of Care</td>
<td>PS&amp;R II-B page 23</td>
<td>ACAP Agreement: Article 2.1, Service Provisions, Section M</td>
<td>CHC Agreement Section V(J) relating to Service Coordination</td>
<td>IFB #6100024102 Section M(b) Version 2/8/13</td>
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<td>§438.208(b)(3)</td>
<td>Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication</td>
<td>HealthChoices Agreement: Exhibit NN Special Needs Unit</td>
<td>PS&amp;R II-4 B)1 m. ix, page 26</td>
<td>ACAP Agreement: Article 2.1 Section M</td>
<td>CHC Agreement Section V(H), relating to Care Management and Care Plans</td>
<td>PA Business Associate Agreement</td>
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<td>§438.208(b)(4)</td>
<td>Protect enrollee privacy when coordinating care</td>
<td>HealthChoices Agreement:</td>
<td>PS&amp;R II-4 B c. page 23 and d. page 24</td>
<td>ACAP Agreement: Article 2.1 Section M</td>
<td>CHC Agreement Section V(M) and V(M)(1) relating to Coordination of Services and CHC-MCO and BH-MCO Coordination</td>
<td>PA Business Associate Agreement</td>
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<td>§438.208(c)(1)</td>
<td>State mechanisms to identify persons with special health care needs</td>
<td>HealthChoices Agreement:</td>
<td>PS&amp;R II-4 B h. page 24</td>
<td>ACAP Agreement: Appendix A</td>
<td>CHC Agreement Section V(CC)(10) relating to Confidentiality</td>
<td>CHIP Policy Manual Section 9.6 Section 19.7, 19.7.1</td>
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<td>§438.208(c)(3)</td>
<td>If applicable, treatment plans developed by the enrollee’s primary care provider with enrollee</td>
<td>HealthChoices Agreement:</td>
<td>PS&amp;R II-4 A.7) page 21</td>
<td>ACAP Agreement: Article 2.1, Service Provisions,</td>
<td>CHC Sections V(E-J) relating to Comprehensive</td>
<td>CHIP Eligibility Handbook</td>
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<td>§438.208(c)(4)</td>
<td>Direct access to specialists for enrollees with special health care needs</td>
<td>HealthChoices Agreement: Section V.S.4. Specialists as PCPs, PS&amp;R II-B 4. h. page 24</td>
<td>Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.1, Service Provisions, Section J</td>
<td>CHC Agreement Section V(BB)(5) relating to Specialists as PCPs</td>
<td>IFB #6100024102 Section J (5) Section M (3) Version 2/8/13</td>
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<td>§438.210(a)(1)</td>
<td>Identify, define, and specify the amount, duration, and scope of each service</td>
<td>HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope, Section V.B.1. General Prior Authorization Requirements, PS&amp;R II-B 3)b. page 28 and C.2) page 32</td>
<td>Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.4, Service Authorization Section J</td>
<td>CHC Agreement V(A)(1) relating to the Amount, Duration and Scope CHC Agreement Section V(A) relating to Covered Services CHC Agreement Section V(B)</td>
<td>CHIP Policy Manual Chapter 37 – Benefits Package</td>
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participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards
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<td>§438.210(a)(2)</td>
<td>Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid</td>
<td>HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope, Section V.B.1. General Prior Authorization Requirements</td>
<td>II-4 B. 3 .b page 28 Quality Strategy APPENDIX E</td>
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<td>relating to Prior Authorization of Services</td>
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<td>§438.210(a)(3)</td>
<td>Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished</td>
<td>HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope, Section V.B.1. General Prior Authorization Requirements</td>
<td>PS&amp;R 3) Denial of Service page 40 Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.1, Service Provisions, Section R</td>
<td>CHC Agreement V(A)(1) relating to the Amount, Duration and Scope</td>
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<td>§438.210(a)(3)</td>
<td>No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition</td>
<td>HealthChoices Agreement: Section V.A.1. Amount, Duration and Scope</td>
<td>PS&amp;R 3) Denial of Service page 40 Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.4, Service Authorization Section G</td>
<td>CHC Agreement V(A)(1) relating to the Amount, Duration and Scope</td>
<td>IFB #6100024102 Section M (1)(e) Version 2/8/13</td>
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<td>§438.210(a)(3)</td>
<td>Each MCO/PIHP may place appropriate limits on a service, such as medical necessity</td>
<td>HealthChoices Agreement: Section II. Definitions</td>
<td>PS&amp;R II-4 C.2 i) page 32 Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Appendix D</td>
<td>CHC Agreement V(B)(1) relating to Prior Authorization of Services</td>
<td>IFB #6100024102 Section J(l)(4) Version 2/8/13 SPA 12, Section 4.2.2, Section 4.2.3</td>
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<td>§438.210(a)(4)</td>
<td>Specify what constitutes “medically necessary services”</td>
<td>HealthChoices Agreement:</td>
<td>PS&amp;R Definition page xi</td>
<td>ACAP Agreement: Article 1.22</td>
<td>CHC Section II relating to</td>
<td>Medical Necessity defined in CHIP Transmittal 2013-1</td>
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<td>§438.210(b)(1)</td>
<td>Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services</td>
<td>HealthChoices Agreement: Section V.B.1. General Prior Authorization Requirements</td>
<td>PS&amp;R II-5 F 3) page 54 BH-MCO POLICY Review and approval by OMHSAS every 3 years or if a policy changes</td>
<td>ACAP Agreement: Article 2.4 Service Authorization Section B</td>
<td>CHC Agreement V(B)(1) relating to Prior Authorization of Services</td>
<td>IFB #6100024102 Section L (18) Version 2/8/13 SPA 12, Section 7.2.4</td>
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<td>§438.210(b)(2)</td>
<td>Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions</td>
<td>HealthChoices Agreement: Section V.B.1. General Prior Authorization Requirements</td>
<td>PS&amp;R Appendix AA Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.4 Service Authorization Sections A thru L</td>
<td>CHC Agreement V(B)(1) relating to Prior Authorization of Services</td>
<td>IFB #6100024102 Section L (18) Version 2/8/13 SPA 12, Section 7.2.4</td>
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<td>§438.210(b)(3)</td>
<td>Any decision to deny or reduce services is made by an appropriate health care professional</td>
<td>HealthChoices Agreement: Medically Necessary definition, Section V.B.1. General Prior Authorization Requirements</td>
<td>PS&amp;R Appendix AA II-4 E. 3) Denial of Services page 40 Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.4 Service Authorization, Section B and C</td>
<td>CHC Agreement V(B)(1) relating to Prior Authorization of Services</td>
<td>SPA 12, Section 3.2</td>
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<td>§438.210(c)</td>
<td>Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested</td>
<td>HealthChoices Agreement: Section V.B.2. Time Frames for Notice of Decisions, Exhibit N(1) Standard Denial Notice-Complete</td>
<td>PS&amp;R Definition of Denial of Services – page viii; II-4 E. 3) Denial of Services page 40 Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.4 Service Authorization Section C and J 5 Appendix G</td>
<td>CHC Agreement V(B)(1) relating to Prior Authorization of Services</td>
<td>SPA 12, Section 7.2</td>
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<td>§438.210(d)</td>
<td>Provide for the authorization decisions and notices as set forth in §438.210(d)</td>
<td>HealthChoices Agreement: Section V.B. Prior Authorization of Services</td>
<td>PS&amp;R Appendix AA Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 2.4 Service Authorization Section</td>
<td>CHC Agreement V(B)(1) relating to Prior Authorization of Services</td>
<td>SPA 12, Section 7.2.4</td>
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<td>§438.210(e)</td>
<td>Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services</td>
<td>HealthChoices Agreement: Section V.T.6. Delegated Quality Management and Utilization Management Functions</td>
<td>PS&amp;R II-2 B. 2) page 10 3) Quality Management page 57</td>
<td>ACAP Agreement: Article 2.4, Service Authorization, Section D</td>
<td>CHC Agreement V(CC)(8) relating to Delegated Quality Management and Utilization Management Functions</td>
<td>SPA 12, Section 3.2, Section 9.5</td>
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**Structure and Operations Standards:**

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<td>§438.214(a)</td>
<td>Written policies and procedures for selection and retention of providers</td>
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<td>§438.214(b)(1)</td>
<td>Uniform credentialing and recredentialing policy that each MCO/PIHP must follow</td>
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<td>§438.214(b)(2)</td>
<td>Documented process for credentialing and recredentialing that each MCO/PIHP must follow</td>
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<td>§438.214(c)</td>
<td>Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment</td>
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<td>§438.214(d)</td>
<td>MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs</td>
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<td>§438.218</td>
<td>Enrollee Information</td>
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<td>§438.226</td>
<td>Enrolllment and Disenrollment</td>
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<td>§438.226</td>
<td>Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in § 438.56</td>
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<td>§438.228</td>
<td>Grievance Systems</td>
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<td>§438.228(a)</td>
<td>Grievance system meets the requirements of Part 438, Subpart F</td>
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<td>§438.228(b)</td>
<td>If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner</td>
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<td>§438.230</td>
<td>Subcontractual Relationships and Delegation</td>
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<td>§438.230(a)</td>
<td>Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities</td>
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<tr>
<td>§438.230(b)(1)</td>
<td>Before any delegation, each MCO/PIHP must evaluate prospective subcontractor’s ability to perform</td>
</tr>
<tr>
<td>§438.230(b)(2)</td>
<td>Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate</td>
</tr>
<tr>
<td>§438.230(b)(3)</td>
<td>Monitoring of subcontractor performance on an ongoing basis</td>
</tr>
<tr>
<td>§438.230(b)(4)</td>
<td>Corrective action for identified deficiencies or areas for improvement</td>
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<tr>
<td>Subcontractors; in addition, corrective action is noted throughout the agreement for specific areas, e.g., prior authorization</td>
<td>HealthChoices Agreement: Exhibit M(1) Quality Management and Utilization Management Program Requirements, Standard III</td>
</tr>
<tr>
<td>Quality Assessment and Performance Improvement Program</td>
<td></td>
</tr>
<tr>
<td>Each MCO and PIHP must have an ongoing quality assessment</td>
<td>HealthChoices Agreement: PS&amp;R II-5 G. 3.b page 58</td>
</tr>
<tr>
<td>Measurement and Improvement Standards:</td>
<td></td>
</tr>
<tr>
<td>§438.236</td>
<td>Practice Guidelines</td>
</tr>
<tr>
<td>§438.236(b)</td>
<td>Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.</td>
</tr>
<tr>
<td>§438.236(c)</td>
<td>Dissemination of practice guidelines to all providers, and upon request, to enrollees</td>
</tr>
<tr>
<td>§438.240</td>
<td>Quality Assessment and Performance Improvement Program</td>
</tr>
<tr>
<td>§438.240(a)</td>
<td>Each MCO and PIHP must have an ongoing quality assessment</td>
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<tr>
<td>§438.240(b)(3)</td>
<td>Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services</td>
<td>HealthChoices Agreement: Exhibit M(1), Quality Management and Utilization Management Program Requirements</td>
<td>Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 6.1 Quality Management Section A 5</td>
<td>CHC Agreement Exhibit K(1) relating to QM/UM Program Requirements</td>
<td>Incident Reporting and Management, and HEDIS® and CAHPS systems</td>
</tr>
<tr>
<td>§438.240(b)(4)</td>
<td>Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs</td>
<td>HealthChoices Agreement: Section V.P. Special Needs Unit (SNU), Exhibit NN Special Needs Unit</td>
<td>PS&amp;R II-5 G. 2 page 57</td>
<td>ACAP Agreement: Article 6.1 Quality Management Section A 5</td>
<td>CHC Agreement Section V(CC), relating to Quality Management and Utilization Management Program Requirements</td>
<td>CHC Agreement Exhibits K(1), K(2), K(3) and K(4) relating to QM/UM Program Requirements, External Quality Review, Critical Incident Reporting and Management, and HEDIS® and CAHPS systems</td>
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<td>CHC Agreement K(1) relating to QM/UM Program Requirements</td>
<td>CHIP Policy Manual Chapter 9.5 Children with Special Needs</td>
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<td>§438.240(e)</td>
<td>Annual review by the state of each quality assessment and performance improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.</td>
<td>HealthChoices Agreement: Exhibit M(1) Quality Management and Utilization Management Program Requirements Exhibit M(3) Quality Management/Utilization Management Deliverables</td>
<td>PS&amp;R II-5 G. 9. Page 60 Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 6.3 Departmental Monitoring Section A</td>
<td>CHC Agreement Section V(CC), relating to Quality Management and Utilization Management Program Requirements CHC Agreement Exhibits K(1), K(2), K(3) and K(4) relating to QM/UM Program Requirements External Quality Review, Critical Incident Reporting and Management, and HEDIS® and CAHPS systems</td>
<td>IFB #6100024102 Section DD Version 2/8/13</td>
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<td>§438.242(b)(1)</td>
<td>Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees</td>
<td>HealthChoices Agreement; Section V.F.12. Services for New Members, Section V.O.7. Management Information Systems, Exhibit CC Data Support for PH-MCOs</td>
<td>PS&amp;R II-7 K.3 page 87 Quality Strategy APPENDICES E, K, &amp; L</td>
<td>ACAP Agreement: Article 10.1, Reporting Sections A and B</td>
<td>CHC Agreement Section V(CC), relating to Quality Management and Utilization Management Program Requirements</td>
<td>IFB #6100024102 Section X Version 2/8/13</td>
</tr>
<tr>
<td>§438.242(b)(2)</td>
<td>Each MCO and PIHP must ensure data received is accurate and complete</td>
<td>HealthChoices Agreement: Section V.O.7. k. Management Information Systems</td>
<td>Quality Strategy APPENDIX E</td>
<td>ACAP Agreement: Article 10.1 Reporting requirements Section</td>
<td>CHC Agreement Section VIII(B)(1)(c) and (e), relating to Data Completeness and Data</td>
<td>CHIP Policy Manual Chapter 15 Enrollment Procedure</td>
</tr>
</tbody>
</table>
### SECTION IV: IMPROVEMENT and INTERVENTIONS:

Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to:
- Cross-state agency collaborative;
- Pay-for-performance or value-based purchasing initiatives;
- Accreditation requirements;
- Grants;
- Disease management programs;
- Changes in benefits for enrollees;
- Provider network expansion, etc.

Describe how the state’s planned interventions tie to each specific goal and objective of the quality strategy.

**Intermediate Sanctions:**

For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 CFR Part 438, Subpart I.

Specify the state’s methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.

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<tbody>
<tr>
<td>Health Information Technology:</td>
<td>Detail how the state’s information system supports initial and ongoing operation and review of the state’s quality strategy.</td>
<td>Quality Strategy OMAP Chapter, State Standards Section</td>
<td>Quality Strategy OMHSAS Chapter, Information Management Section</td>
<td>Quality Strategy ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter, State Standards Section</td>
<td>Quality Strategy CHIP Chapter, State Standards Section</td>
</tr>
<tr>
<td>Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state’s quality strategy and ensure the state is progressing toward its stated goals.</td>
<td>Quality Strategy OMAP Chapter, State Standards Section</td>
<td>Quality Strategy OMHSAS Chapter, Information Management Section</td>
<td>Quality Strategy ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter, State Standards Section</td>
<td>Quality Strategy CHIP Chapter, State Standards Section</td>
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<tr>
<td>SECTION V: DELIVERY SYSTEM REFORMS:</td>
<td>Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.</td>
<td>Quality Strategy OMAP Chapter, Improvements and Interventions and Delivery Systems Reforms Sections</td>
<td>Quality Strategy OMHSAS Chapter, Information Management, Improvements and Interventions, and Delivery System Reforms Sections</td>
<td>Quality Strategy ACAP Chapter Introduction Section</td>
<td>Quality Strategy OLTL Chapter, Improvements and Interventions Section and Delivery Systems Reforms Section and Introduction Section</td>
<td>Quality Strategy Introduction</td>
</tr>
<tr>
<td>List any performance measures applicable to this</td>
<td>Quality Strategy OMAP Chapter,</td>
<td>Quality Strategy OMHSAS Chapter,</td>
<td>Quality Strategy Introduction</td>
<td>Quality Strategy OLTL Chapter,</td>
<td>Quality Strategy Introduction,</td>
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<td>population/service, as well as the reasons for collecting these performance measures.</td>
<td>Improvements and Interventions and Delivery Systems Reforms Sections</td>
<td>Information Management, Improvements and Interventions, and Delivery System Reforms Sections</td>
<td>ACAP Chapter Introduction Section</td>
<td>Improvements and Interventions Section and Delivery Systems Reforms Section</td>
<td>Assessment Section, State Standards Section</td>
</tr>
<tr>
<td></td>
<td>List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.</td>
<td>Quality Strategy OMAP Chapter, Improvements and Interventions and Delivery Systems Reforms Sections</td>
<td>Quality Strategy OMHSAS Chapter, Information Management, Improvements and Interventions, and Delivery System Reforms Sections</td>
<td>Quality Strategy OMHSAS Chapter, Information Management, Improvements and Interventions, and Delivery System Reforms Sections</td>
<td>Quality Strategy OLTL Chapter, Improvements and Interventions Section and Delivery Systems Reforms Section</td>
<td>Quality Strategy CHIP Chapter, Assessment Section, State Standards Section</td>
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<td></td>
<td>Address any assurances required in the state’s Special Terms and Conditions (STCs), if applicable.</td>
<td>N/A</td>
<td>Optional Component</td>
<td>N/A</td>
<td>N/A</td>
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**SECTION VI: CONCLUSIONS and OPPORTUNITIES:**

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<td>Identify any successes that the state considers to be best or promising practices.</td>
<td>Quality Strategy, OMAP, HealthChoices, A.6. Conclusions and Opportunities</td>
<td>N/A</td>
<td>Quality Strategy ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter</td>
<td>Quality Strategy CHIP Chapter, Plan for Improvement and Conclusion Section</td>
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<tr>
<td>Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.</td>
<td>Quality Strategy, OMAP, HealthChoices, A.6. Conclusions and Opportunities</td>
<td>N/A</td>
<td>Quality Strategy ACAP Chapter, Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter</td>
<td>Quality Strategy CHIP Chapter, Plan for Improvement and Conclusion Section</td>
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<tr>
<td>Include a discussion of challenges or opportunities with data</td>
<td>Quality Strategy, OMAP,</td>
<td>N/A</td>
<td>Quality Strategy ACAP Chapter,</td>
<td>Quality Strategy OLTL, CHC</td>
<td>Quality Strategy CHIP Chapter,</td>
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<td>collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.</td>
<td>HealthChoices, A.5. Delivery System Reforms</td>
<td>Conclusions and Opportunities Section</td>
<td>Delivery System Reforms</td>
<td>State Standards</td>
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<td>Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.</td>
<td>Quality Strategy OMAP Chapter, State Standards and Improvements and Interventions Sections</td>
<td>Quality Strategy OMHSAS Chapter, Improvements and Interventions, and Delivery System Reforms Sections</td>
<td>Quality Strategy Document, ACAP Chapter Conclusions and Opportunities Section</td>
<td>Quality Strategy OLTL Chapter, Improvements and Interventions Section and Delivery Systems Reforms Section</td>
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Appendix D: The Pennsylvania Department of Human Services (Vision, Mission, and DHS Core Values) and the Office of Mental Health and Substance Abuse Services (Goals and Guiding Principles)

Department of Human Services:

Vision Statement: *Our vision is to see Pennsylvanians living safe, healthy, and independent lives.*

Mission Statement: *Our Mission is to improve the quality of life for Pennsylvania’s individuals and families. We promote opportunities for independence through services and supports while demonstrating accountability for taxpayer resources.*

Core Values:

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

Office of Mental Health and Substance Abuse Services:

OMHSAS Goals:

1. Transform the children’s behavioral health system to a system that is family-driven and youth-guided.
2. Implement services and policies to support recovery and resiliency in the adult behavioral health system.
3. Ensure that behavioral health services and supports recognize and accommodate the unique health system.
4. Ensure that behavioral health services and supports recognize and accommodate the unique needs of older adults.
OMHSAS Guiding Principles:

The mental health and substance abuse service system will provide quality services and supports that:

1. Facilitate recovery for adults and resiliency for children.
2. Are responsive to individuals’ unique strengths and needs throughout their lives.
3. Focus on prevention and early intervention.
4. Recognize, respect, and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity, and sexual orientation.
5. Ensure individual human rights and eliminate discrimination and stigma.
6. Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family.
7. Are developed, monitored, and evaluated in partnership with beneficiaries, families, and advocates.
8. Represent collaboration with other agencies and service systems.
Appendix E: Quality Toolkit Review of HCBH Contract Agreement & PEPS Standards to Federal Requirements

OMHSAS abbreviations: PS&R = (HCBH Program Standards & Requirements Agreement
PEPS = Program Evaluation Performance Summary

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<td><strong>Managed Care Goals, Objectives, and Overview:</strong></td>
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<td></td>
<td>Include a brief history of the state’s Medicaid (and CHIP, if applicable) managed care programs.</td>
<td>Quality Strategy Intro</td>
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<td>Include general information about the state’s decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.</td>
<td>Quality Strategy Intro</td>
</tr>
<tr>
<td>§438.202(b)</td>
<td>Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.</td>
<td>Quality Strategy Intro</td>
</tr>
<tr>
<td>§438.202(b)</td>
<td>Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.</td>
<td>Quality Strategy Intro</td>
</tr>
<tr>
<td>§438.202(d)</td>
<td>Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).</td>
<td>PEPS 91.10</td>
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<tr>
<td>§438.202(d)</td>
<td>Include a timeline for modifying or updating the quality strategy. If this is based on an</td>
<td>Quality</td>
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<td>Rule Reference</td>
<td>Description</td>
<td>Strategy/PEPS</td>
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<td>§438.204(b)(1)</td>
<td>Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state’s definition of special health care needs.</td>
<td>Quality Strategy Intro PEPS 91.5</td>
</tr>
<tr>
<td>§438.204(b)(2)</td>
<td>Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.</td>
<td>Quality Strategy</td>
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<tr>
<td>§438.204(c)</td>
<td>Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.</td>
<td>Quality Strategy</td>
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<td>Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.</td>
<td>Quality Strategy</td>
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§438.204(b)(3) Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of Subpart D (access, structure and operations, and measurement and improvement standards).

Some examples of mechanisms that may be used for monitoring include, but are not limited to:

- Member or provider surveys;
- HEDIS® results;
- Report Cards or profiles;
- Required MCO/PIHP reporting of performance measures;
- Required MCO/PIHP reporting on performance improvement projects;
- Grievance/Appeal logs, etc.


§438.204(d) Include a description of the state’s arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract.

Identify what entity will perform the EQR and for what period of time.

Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform.

The five optional activities include:

1. Validation of encounter data reported by an MCO or PIHP.
2. Administration or validation of beneficiary or provider surveys of quality of care.
3. Calculation of performance measures in addition to those reported by an MCO or PIHP.

Quality Strategy PEPS 91.1-91.13
and validated by an EQRO.

4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO.

5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

| §438.360(b)(4) | If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR § 438.204(g). | NA PA BH HC does not deem any compliance results based upon Medicare reviews or accreditation results |
| §438.360(c)(4) | If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication option under § 438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2). | NA See above |

<p>| §438.206 | Availability of Services |
| §438.206(b)(1) | Maintains and monitors a network of appropriate providers | See Appendix B of Quality Strategy Ref.: PS&amp;R, July 1, 2014; pp. 24-6. Section II-4. B. Coordination of Care 1) h., k., m. x); E. Provider |
| §438.206(b)(2) | Female enrollees have direct access to a women's health specialist | NA Specific citation deals with women's routine and preventive health care services. Not Applicable to BH HealthChoices Program |
| §438.206(b)(3) | Provides for a second opinion from a qualified health care professional | Ref.: PS&amp;R, July 1, 2014- p.35; Section C. Member Services/Membe r Rights, 2) Member orientation PEPS 1.1-1.7 |
| §438.206(b)(4) | Adequately and timely coverage of services not available in network | Ref.: PS&amp;R, July 1, 2014 Appendix V PEPS 1.1, 1.4-1.7, 93.1 |
| §438.206(b)(5) | Out-of-network providers coordinate with the MCO or PIHP with respect to payment | Ref.: PS&amp;R, July 1, 2014, p. 21: SectionII-4, A. 4) b.; p. 33: e. viii); p. 55: F. 4., 5.; p. 75: Section II-7. F.; p. 79: I. 2) |
| §438.206(b)(6) | Credential all providers as required by § 438.214 | Ref.: PS&amp;R, July 1, 2014, p. 49: Section II-5. D. |
| §438.206(c)(1) | Providers meet state standards for timely access to care and services | Refer: PS&amp;R, July 1, 2014 p. 19-20, 21: II-4. A. In-Plan services 1), 8); p. 54: F. Service Access PEPS 23.2, 24.2-24.6, 93.1 |
| §438.206(c)(1) | Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service | Refer: PS&amp;R, July 1, 2014 p. 20: II-4, A. 2); p. 53: F. Service Access, 1. |
| §438.206(c)(1) | Services included in the contract are available 24 hours a day, 7 days a week | Refer: PS&amp;R, July 1, 2014 p. 13: II-3., B. 5); p. 22: II-4, A. 8); p. 53: F. Service Access, 1. |
| §438.206(c)(2) | Culturally competent services to all enrollees | Refer: PS&amp;R, July 1, 2014 Section II-5.D.1 b and c. on page 48 and e. on page 49; Appendix CC PEPS 23.2-23.5 |
| §438.206(c)(1) | Mechanisms/monitoring to ensure compliance by providers | Refer: PS&amp;R, July 1, 2014 Sections I-5. On-Site Reviews (p. 3), I-20. Project Monitoring (p. 8); p. |</p>
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<th>§ 438.207</th>
<th>Assurances of Adequate Capacity and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.207(a)</td>
<td>Assurances and documentation of capacity to serve expected enrollment</td>
</tr>
<tr>
<td>Ref.: PS&amp;R, July 1, 2014 II-5 D. 1 – page 48 PEPS 1.6</td>
<td></td>
</tr>
<tr>
<td>§438.207(b)(1)</td>
<td>Offer an appropriate range of preventive, primary care, and specialty services</td>
</tr>
<tr>
<td>Ref.: PS&amp;R, July 1, 2014 II-4 C.3) page 37 II-5D.1 pages 48 and 49 PEPS 1.1, 1.4</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>§438.207(b)(2)</td>
<td>Maintain network sufficient in number, mix, and geographic distribution</td>
</tr>
<tr>
<td>§438.208</td>
<td>Coordination and Continuity of Care</td>
</tr>
<tr>
<td>§438.208(b)(1)</td>
<td>Each enrollee has an ongoing source of primary care appropriate to his or her needs</td>
</tr>
<tr>
<td>§438.208(b)(2)</td>
<td>All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP</td>
</tr>
<tr>
<td>§438.208(b)(3)</td>
<td>Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services</td>
</tr>
<tr>
<td>§438.208(b)(4)</td>
<td>Protect enrollee privacy when coordinating care</td>
</tr>
<tr>
<td>§438.208(c)(1)</td>
<td>State mechanisms to identify persons with special health care needs</td>
</tr>
<tr>
<td>§438.208(c)(2)</td>
<td>Mechanisms to assess enrollees with special health care needs by appropriate health care professionals</td>
</tr>
<tr>
<td>§438.208(c)(3)</td>
<td>If applicable, treatment plans developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards</td>
</tr>
<tr>
<td>§438.208(c)(4)</td>
<td>Direct access to specialists for enrollees with special health care needs</td>
</tr>
<tr>
<td>§438.210</td>
<td>Coverage and Authorization of Services</td>
</tr>
<tr>
<td>§438.210(a)(1)</td>
<td>Identify, define, and specify the amount, duration, and scope of each service</td>
</tr>
<tr>
<td>§438.210(a)(2)</td>
<td>Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid</td>
</tr>
<tr>
<td>§438.210(a)(3)</td>
<td>Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished</td>
</tr>
<tr>
<td>§438.210(a)(3)</td>
<td>No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition</td>
</tr>
<tr>
<td>§438.210(a)(3)</td>
<td>Each MCO/PIHP may place appropriate limits on a service, such as medical necessity</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>§438.210(b)(1)</td>
<td>Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services</td>
</tr>
<tr>
<td>§438.210(b)(2)</td>
<td>Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions</td>
</tr>
<tr>
<td>§438.210(b)(3)</td>
<td>Any decision to deny or reduce services is made by an appropriate health care professional</td>
</tr>
<tr>
<td>§438.210(c)</td>
<td>Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested</td>
</tr>
<tr>
<td>§438.210(d)</td>
<td>Provide for the authorization decisions and notices as set forth in § 438.210(d)</td>
</tr>
<tr>
<td>§438.210(e)</td>
<td>Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services</td>
</tr>
<tr>
<td>§438.214</td>
<td>Provider Selection</td>
</tr>
<tr>
<td>§438.214(a)</td>
<td>Written policies and procedures for selection and retention of providers</td>
</tr>
<tr>
<td>§438.214(b)(1)</td>
<td>Uniform credentialing and recredentialing policy that each MCO/PIHP must follow</td>
</tr>
<tr>
<td>§438.214(b)(2)</td>
<td>Documented process for credentialing and recredentialing that each MCO/PIHP must follow</td>
</tr>
<tr>
<td>§438.214(c)</td>
<td>Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment</td>
</tr>
<tr>
<td>§438.214(d)</td>
<td>MCOs/PIHPs may not employ or contract with providers excluded from federal health care programs</td>
</tr>
<tr>
<td>§438.214(e)</td>
<td>Comply with any additional requirements established by the state</td>
</tr>
<tr>
<td>§438.218</td>
<td>Enrollee Information</td>
</tr>
<tr>
<td>§438.218</td>
<td>Incorporate the requirements of § 438.10</td>
</tr>
<tr>
<td>§438.224</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>§438.224</td>
<td>Individually identifiable health information is disclosed in accordance with federal privacy requirements</td>
</tr>
<tr>
<td>§438.226</td>
<td>Enrollment and Disenrollment</td>
</tr>
<tr>
<td>§438.226</td>
<td>Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in § 438.56</td>
</tr>
<tr>
<td>§438.228</td>
<td>Grievance Systems</td>
</tr>
<tr>
<td>§438.228(a)</td>
<td>Grievance system meets the requirements of Part 438, Subpart F</td>
</tr>
<tr>
<td>§438.228(b)</td>
<td>If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner</td>
</tr>
<tr>
<td>§438.230</td>
<td>Subcontractual Relationships and Delegation</td>
</tr>
<tr>
<td>§438.230(a)</td>
<td>Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities</td>
</tr>
<tr>
<td>§438.230(b)(1)</td>
<td>Before any delegation, each MCO/PIHP must evaluate prospective subcontractor’s ability to perform</td>
</tr>
<tr>
<td>§438.230(b)(2)</td>
<td>Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate</td>
</tr>
<tr>
<td>§438.230(b)(3)</td>
<td>Monitoring of subcontractor performance on an ongoing basis</td>
</tr>
<tr>
<td>§438.230(b)(4)</td>
<td>Corrective action for identified deficiencies or areas for improvement</td>
</tr>
<tr>
<td>§438.236</td>
<td>Practice Guidelines</td>
</tr>
<tr>
<td>§438.236(b)</td>
<td>Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.</td>
</tr>
<tr>
<td>§438.236(c)</td>
<td>Dissemination of practice guidelines to all providers, and upon request, to enrollees</td>
</tr>
<tr>
<td>§438.240</td>
<td>Quality Assessment and Performance Improvement Program</td>
</tr>
<tr>
<td>§438.240(a)</td>
<td>Each MCO and PIHP must have an ongoing quality assessment and performance improvement program</td>
</tr>
<tr>
<td>§438.240(b)(1) &amp; §438.240(d)</td>
<td>Each MCO and PIHP must conduct PIPs and measure and report to the state its performance List out PIPs in the quality strategy</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| §438.240(b)(2) & §438.240(c) | Each MCO and PIHP must measure and report performance measurement data as specified by the state  
List out performance measures in the quality strategy | Ref.: PS&R, July 1, 2014, II-5 G. 3.b page 58  
PEPS 104.1, 104.2  
Ref.: PS&R, July 1, 2014, II-5 G. 2 page 57  
PEPS 91.5 |
| §438.240(b)(3) | Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services | PEPS 98.2, 91.5 |
| §438.240(b)(4) | Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs | Ref.: PS&R, July 1, 2014, II-5 G. 9. Page 60  
PEPS 91.1-91.13 |
| §438.240(e) | Annual review by the state of each quality assessment and performance improvement program  
If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy. | Ref.: PS&R, July 1, 2014, II-5 G. 9. Page 60  
PEPS 91.1-91.13 |
| §438.242 | Health Information Systems                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |
| §438.242(a) | Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility | Ref.: PS&R, July 1, 2014, II-7 K.2  
Page 86  
PEPS 120.1 |
| §438.242(b)(1) | Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees | Ref.: PS&R, July 1, 2014, II-7 K.3  
Page 87  
PEPS 120.1 |
| §438.242(b)(2) | Each MCO and PIHP must ensure data received is accurate and complete | PEPS 120.1 |
| | Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to:  
• Cross-state agency collaborative; | Quality Strategy |
| §438.204(e) | For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 CFR Part 438, Subpart I. |
| §438.204(f) | Detail how the state’s information system supports initial and ongoing operation and review of the state’s quality strategy. |
| | Describe how the state’s planned interventions tie to each specific goal and objective of the quality strategy. |
| | Specify the state’s methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems. |
| | Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state’s quality strategy and ensure the state is progressing toward its stated goals. |
Appendix F: Follow-Up After Hospitalization for Mental Illness – OMHSAS Goal (2014 - 2016)

OMHSAS has designed a three-year plan to support improved and sustained performance for Follow-Up after Hospitalization (FUH) for Mental Illness. The three-year plan includes performance goals that are largely based on the national Healthcare Effectiveness Data and Information Set (HEDIS®) benchmarks. The three-year plan also provides the opportunity to more closely evaluate and address frequency (access) and quality (establishment of statewide best practices) issues related to FUH. The intended impact is to enhance the effectiveness of transition supports and services for members and effectuate a reduction of the statewide 30, 60 and 90 day readmission rates.

**Goal**

The methodology used to determine whether a Root Cause Analysis is assigned to the BH-MCO for Follow-Up after Hospitalization (FUH) for Mental Illness (HEDIS® 7 and 30 day) as part of their requirements is based on the following goal methodology.

The three-year OMHSAS goal is to achieve the 75th percentile for ages 6-64, based on the annual HEDIS® published benchmarks for 7-day and 30-day FUH.

1. Performance goals will be established for each county/primary contractor (C/PC) for years 1(2014) and 2(2015).
   a. Any C/PC below the 50th percentile must increase performance by up to 5 percent (no less than 2 percent) in order to achieve the 50th Percentile for the subsequent year.
   b. Any C/PC above the 50th percentile and below the 75th percentile must increase performance by 2 percent over the previous year. (Note: Any C/PC having the previous year performance within 2 percent of the 75th percentile will have the performance improvement goal set at the 75th percentile rate.)
2. Performance Incentives (pending funding) will be implemented for years 2(2015) and 3(2016).

**Process**

1. Performance will be evaluated at the BH-MCO and County/primary contractor level.
2. Evaluation of performance will occur annually, with data reviews being held every 6 months with BH-MCOs and County/primary contractors.
3. Healthcare Effectiveness Data and Information Set (HEDIS®) published benchmarks for Follow-Up after Hospitalization (FUH) for Mental Illness will be used to establish annual performance goals for 7 and 30 day measures. (Note: HEDIS® benchmarks may increase or decrease each year. This could result in a
County/primary contractor attaining the 75th percentile one year and not the next, even though the same FUH rate was achieved during both years.)
4. HEDIS® FUH measure specifications will be used for the following age breakouts:
   - 6 and over
   - 6-64
5. Annually, OMHSAS will provide additional data for more detailed analysis of the 7 day and 30 day FUH Measures by the following age breakouts:
   - 15-20
   - 21-25
   - 6-20
   - 21-64
   - 65 and over

Supporting Objectives

1. Explore impact of TPL specific to Medicare and Commercial Insurance on FUH and loss of data for individuals age 65 and older.
2. OMHSAS, in collaboration with a subgroup of representatives from C/PCs and BH-MCOs, will support the development and implementation of best practices that target transitional supports and services from inpatient care to community care.
3. Additional performance measures will be revised or developed that are designed to support the best practices that are implemented.
Appendix G: Office of Mental Health and Substance Abuse Services: Semiannual Performance Measure (SAPM) Reports

Instructions for Submission of the SAPM Reports

Introduction/Purpose

The HealthChoices BH primary contractor or BH-MCO shall provide DHS with progress updates on the performance measure data. This document outlines the reporting process.

Reporting Methodology

Reporting of semiannual performance data will be completed through a web-based survey format at
https://www.surveymonkey.com/s/OMHSAS_PerformDataActivityReports

The following items will be requested during the survey:

1. Contact Person
   a. Name
   b. Email address
   c. Phone number
2. County/HealthChoices Contract Name
3. Numerator and Denominator data for:
   a. QI-1: HEDIS® 7-day (ages 6-64)
   b. QI-2: HEDIS® 30-day (ages 6-64)
   c. QI-A: PA-Specific 7-day
   d. QI-B: PA-Specific 30-day
   e. REA: Readmission within 30 days of inpatient psychiatric discharge

After submission of the above information, a confirmation page will appear indicating that the submission was successfully received by OMHSAS. This page can be printed (electronic format is encouraged) for record keeping purposes. No other automated confirmation will be provided.

Reporting Periods & Submission Timeframes

Performance Data Activity Reports for each HealthChoices BH primary contractor are to be submitted semiannually no later than 135 days immediately following the end of the six-month reporting period
<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Data Collection Cycle</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semiannual</td>
<td>January 1 through June 30</td>
<td>November 15*</td>
</tr>
<tr>
<td>performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>measure (SAPM) 1</td>
<td>A. July 1 through December 31</td>
<td>May 15*</td>
</tr>
<tr>
<td></td>
<td>B. YTD: Jan 1 through Dec 31</td>
<td></td>
</tr>
</tbody>
</table>

*The due date will automatically fall on the next work day if the 15th of May or November occurs on a weekend or holiday.
Appendix H: Successful Transitions from Inpatient Care to Ambulatory Care

Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services
Performance Improvement Project

Successful Transitions from Inpatient Care to Ambulatory Care

A. INTRODUCTION

The Commonwealth of Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS) has selected the topic, “Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis” as a Performance Improvement Project (PIP) for all Medicaid Behavioral Health Managed Care Organizations (BH-MCOs) in the state. The Performance Improvement Project (PIP) will extend from 2014 through 2017; including a final report due in 2018. While the topic will be common to Behavioral Health HealthChoices (BH HC) Contractors and BH-MCOs, each project will be developed as a collaboration and discussion between BH HC Contractors and their contracted BH-MCOs. BH HC Contractors and BH-MCOs will be conducting independent analyses of their data, with BH HC Contractors and BH-MCOs partnering to develop relevant performance measures and interventions. BH-MCOs will be responsible for coordinating, implementing, and reporting the project.

B. BACKGROUND

Research supports the theory that patients who follow-up with their outpatient appointments and medications after inpatient hospitalization are less likely to be readmitted than patients who do not. However, research additionally indicates outcomes are enhanced if these follow-up appointments are preceded by a clinically-sound bridge between inpatient and outpatient levels of care; further, research demonstrates that patient profiling to identify at-risk patients, medication counseling, ongoing treatment engagement, and outpatient care management can all contribute to reducing readmission rate.

Craig, Fennig, Tanenberg-Karant, & Bromet (2000) researched the correlation between medication adherence and rapid readmission in patients with major depression, bipolar disorder, and schizophrenia. In this study of patients with psychosis, Craig et al. (2000) found that two strong associations with rapid readmissions was the failure to prescribe medication that adequately addressed the patient’s symptoms during the initial stay and medication non-adherence post-discharge. Weiden, Kozma, Grogg, & Locklear (2004) studied 4,325 patients and discovered that patients with schizophrenia who failed to
take medication consistently post-discharge – even if the window of non-adherence was as small as a few days – were at increased risk of readmission. In fact, Weiden et al.’s (2004) research demonstrates that as the length of non-adherence increases, the rate of readmission significantly increases as well. Later in 2010, Laan et al. had similar findings with 477 patients with schizophrenia indicating participants who refilled their psychiatric medications more often were at significantly lower risk for readmission. Tomko et al. (2013) studied patients discharged home from a behavioral health hospitalization with pre-filled prescriptions and medication counseling compared to a control group with traditional discharge services; the research indicated that the experimental group had a reduced rate of readmissions compared to the control group, which was attributed to the availability of filled prescriptions on discharge combined with therapeutic alliance and focus on medication counseling with patient prior to discharge.

This leads to another factor: the transition from inpatient to outpatient treatment through care management. Taylor et al. (2014) studied 195 patients who were treated at a psychiatric hospital; of these individuals, 87 received a transitional care management interview prior to discharge while the other 108 received traditional care. It was found that the 108 patients who received traditional care were more likely to readmit than the 87 patients who received a transitional care management intervention prior to discharge; Taylor et al. (2014) essentially concludes that conducting a transitional intervention before the patient leaves the hospital may be a cost-effective intervention to assist in preventing readmissions. Nelson, Maruish, & Axler (2000) studied 3113 psychiatric admissions, of which 542 were readmissions. From this study, Nelson et al. (2000) concluded that patients who did not attend an outpatient appointment post-discharge were two to three times more likely to be readmitted within a year than patients who kept at least one outpatient appointment; Nelson et al. (2000) continues that patients who kept their outpatient appointments had a 10% chance of readmission, compared to a 25% chance of readmission to those who did not keep their appointments. This concept holds true for patients with a substance abuse diagnosis as well; Mark, Vandivort-Warren, & Montejano (2006) studied records from Medicaid, state mental health, and substance abuse agencies and found that patients who engaged in two or more substance-abuse related services within 30 days post detoxification were at reduced risk of readmission.

While transition of care is critical, continued treatment engagement beyond the first follow-up appointment is equally important. Guidelines published by the American Psychiatric Association (2010) for Major Depression state that for outpatient psychotherapy the acute phase of treatment lasts a minimum of 6-12 weeks. In terms of intensity of outpatient treatment for psychotherapy, the American Psychiatric Association (2010) discusses that many trials have implemented weekly therapy for 12-16 weeks using Cognitive Behavioral Therapy or Interpersonal Therapy modalities. In addition, research by Shapiro et al. (1994) indicates that for more severe depression, 16 weeks of weekly Cognitive Behavioral Therapy sessions were more effective than 8 weeks of weekly Cognitive Behavioral Therapy sessions. Further, research by Frank et al. (1990) demonstrated in a 3-year study that during the maintenance phase of
treatment, monthly interpersonal therapy proved beneficial in reducing relapse in patients with major depression. These guidelines and research support the concept that successful prevention of relapse relies on a sustained period of ongoing treatment, as opposed to just a single follow-up appointment. While successful transition of care and attendance of the first follow-up appointment are vitally important to orient the patient on the path towards recovery, continued weekly sessions post-inpatient discharge may significantly reduce risk of relapse – and thus ultimately reduce risk of readmission.

Research also indicates clinical history may be predictive of readmission risk, highlighting the importance of patient profiling. Olfsen et al. (1999), Bowersox, Saunders, & Berger (2012), Thompson, Neighbors, Munday, and Trierweiler (2003) all found that a past history of readmissions indicated a patient was at high risk of readmission in the future. Olfsen et al. (1999) studied a group of 262 adults with schizophrenia or schizoaffective disorder and concluded that a history of multiple previous readmissions or comorbid substance abuse disorder significantly increased risk of readmissions; Olfsen et al. (1999) also noted that staff underestimated the impact these two factors on readmission risk. Raven et al. (2008) studied encounter data for 36,457 Medicaid patients and similarly found a history of substance abuse as well as lack of social support increased risks of readmission. Bowersox et al. (2012) studied 233 psychiatric patients who were high service utilizers and similarly found that the number of inpatient psychiatric days the patient accumulated the previous year significantly impacted risk of readmission. Thompson et al. (2003) analyzed data from 1481 state psychiatric patients and also concluded that multiple previous readmissions was associated with an increased risk of readmission. Given this common thread found in the above studies, one could postulate that in order to target the patients who are at greatest risk of readmission for intensive treatment, one must study their past hospitalization and substance abuse history; if a patient has a history of multiple readmissions or substance abuse, one should consider this patient at high risk for readmission.

**TOPIC SELECTION**

The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the goal as illustrated in Figure 1. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS®) Follow-Up After Hospitalization (FUH) metrics as illustrated in Figures 2 and 3. Given the research linking readmissions with medication adherence, transition to and robustness of outpatient interventions, as well as clinical history, it became apparent that a re-examination of this research and how it might be applicable to HealthChoices was warranted. With the metrics indicating that there is significant room for improvement, forging a plan to act upon this research is critical to ensure HealthChoices members are receiving the most effective delivery of care.
Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.

* Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.

**HEDIS® Quality Compass Medicaid National HMO Benchmarks.**
C. AIM STATEMENT

Successful transition from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis.

D. OBJECTIVES

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.
2. Increase kept ambulatory follow-up appointments post-inpatient discharge.
3. Improve medication adherence post-inpatient discharge.

E. EXPECTATIONS FOR BH HC CONTRACTORS AND BH-MCOS

The PIP project will extend from January 2014 through December 2017; with a final report due in June 2018, with initial PIP proposals to be developed and submitted in 2014. The non-intervention baseline period will be January 2014 to December 2014. BH-MCOs will be asked to submit a formal PIP proposal, finalized by November 10th 2014. BH-MCOs will additionally be required to submit interim reports in June 2016 and June 2017, as well as a final report in June 2018. Performance indicators and interventions will be developed and customized based on evaluation of contract-level and MCO-level data, including clinical history and pharmacy data. The BH-MCOs and each of their BH HC Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the BH-MCO level of

*HEDIS® Quality Compass Medicaid National HMO Benchmarks.
Each of the barriers identified should include the contributing BH HC Contract level data and illustrate how BH HC Contractor knowledge of their high risk populations contributes to the barriers within their specific BH HC Contract service areas. Each BH-MCO will submit the single root-cause/barrier analysis according to the schedule below. No separate submissions from the BH HC Contracts are required. Each BH HC Contractor is expected to contribute to the planning and implementation of the specific PIP strategies to remediate barriers and improve performance in their BH HC Contract service areas.

BH HC Contractors and BH-MCOs will be required to collaborate to develop and implement the PIP. BH HC Contractors and BH-MCOs may find it advantageous to focus on targeted populations, such as members with a history of readmissions, non-adherence with follow-up appointments, and medication non-adherence. BH-MCOs and BH HC Contractors will be asked to participate in multi-plan PIP update calls through the duration of the PIP to report on their progress or barriers to progress. Frequent collaboration between OMHSAS, BH HC Contractors and BH-MCOs is also expected. IPRO will provide technical assistance throughout the project.

F. MEASUREMENT PERIODS

<table>
<thead>
<tr>
<th>Period</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Period</td>
<td>January 2014</td>
<td>December 2014</td>
</tr>
<tr>
<td>Year 1 Measurement</td>
<td>January 2015</td>
<td>December 2015</td>
</tr>
<tr>
<td>Year 2 Measurement</td>
<td>January 2016</td>
<td>December 2016</td>
</tr>
<tr>
<td>Sustainability Measurement</td>
<td>January 2017</td>
<td>December 2017</td>
</tr>
</tbody>
</table>

G. SAMPLE TIMELINE TABLES

These tables are not meant to be prescriptive. Based on your results, you may decide to begin analysis or development earlier than the dates below.

Sample Analysis Schedule

<table>
<thead>
<tr>
<th>Type</th>
<th>Target Start</th>
<th>Actual Start</th>
<th>End</th>
</tr>
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<tbody>
<tr>
<td>Initial Barrier Analysis</td>
<td>November 2014</td>
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<td></td>
</tr>
<tr>
<td>Establish Baseline</td>
<td>April 2015</td>
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<tr>
<td>Analysis of Process Measures Y1Q1</td>
<td>April 2015</td>
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<tr>
<td>Analysis of Process Measures Y1Q2</td>
<td>July 2015</td>
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</tr>
<tr>
<td>Analysis Y1 Performance</td>
<td>April 2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sample Intervention Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Start</th>
<th>Actual Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 Intervention 1 Development</td>
<td>November 2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### H. BARRIER ANALYSIS

Barrier analysis should be conducted as part of the project design. Barrier analysis is an integral part of intervention selection and development. Barrier analysis should be based on available data. Examples of data sources include claims data, data derived from review of charts and cases, data derived from case management programs and information derived from focus groups, including, but not limited to patients, families, and care givers, and discussions with ambulatory providers and inpatient facilities.

### I. INTERVENTIONS

Interventions should address the barriers identified and should be reasonable and practical to implement considering the target population and the resources of the BH HC Contractors and BH-MCOs. Interventions should be of sufficient strength to bring about change in the target metrics. Issues to consider in developing interventions include the degree to which they are targeting the appropriate population and the extent to which they are active interventions rather than passive interventions. Passive interventions include general mailings. An example of an active intervention is a face-to-face meeting with a facility to deliver targeted messaging around appropriate discharge practice. The following are some examples of interventions. This is not intended as a prescriptive list. BH HC Contractors and BH-MCOs should develop interventions that are specific to the barriers identified for their populations.

- Intensive Care Management engagement of at-risk members while hospitalized and regular outreach to at-risk members from inpatient through outpatient levels of care.
- Provide targeted education of patients prior to discharge in taking medications correctly and consistently to reduce probability of symptom relapse.
• Embed staff exclusively tasked with discharge planning at inpatient facilities to design comprehensive discharge plans in a timely fashion.
• Provide targeted educational intervention to participating facilities relating to appropriate discharge planning including, but not limited to, reconciliation of medications and scheduling of ambulatory appointments.
• Integration of family members and/or social supports into the discharge planning process when permitted by member.

J. CORE PERFORMANCE MEASURES

• Readmission within 30 Days of Inpatient Psychiatric Discharge (BHR – Mental Health Discharges).
• Readmission within 30 Days of Inpatient Substance Abuse Discharge (BHR – Substance Abuse Discharges).
• Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA).
• Components of Discharge Management Planning (DMP).
  o Percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: Appointment dates, appointment times, provider names, provider addresses and provider phone numbers – BH-MCOs are to calculate this measure by abstracting a sample of charts from inpatient facilities (DMP Combinations 1 and 2).
  o Percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: Appointment dates, appointment times, provider names, provider addresses and provider phone numbers where at least one of the scheduled appointments occurred – BH-MCOs are to calculate this measure by abstracting a sample of charts from inpatient facilities (DMP Combination 3).

K. EXAMPLES OF PERFORMANCE MEASURES

• Readmission within 60 Days of Inpatient Psychiatric Discharge.
• Readmission within 60 Days of Inpatient Substance Abuse Discharge.
• Readmission within 90 Days of Inpatient Psychiatric Discharge.
• Readmission within 90 Days of Inpatient Substance Abuse Discharge.
• HEDIS® Follow-Up After Hospitalization 7-day (FUH7).
• HEDIS® Follow-Up After Hospitalization 30-day (FUH30).
• PA-specific Follow-Up After Hospitalization 7-day.
• PA-specific Follow-Up After Hospitalization 30-day.
• Antidepressant Medication Management (AMM).
• Percentage of same-day bridge appointments successfully completed for HealthChoices inpatient discharges.
• Percentage of same-day bridge appointments which include medication reconciliation.
• Percentage of discharges including collaboration with the member’s family during the discharge planning process.
• Percentage of discharges including discharge plans that both identify at least one significant social support (family member, close friend, clergy, peer support services, etc.) and describe the method in which that social support will help the member achieve community tenure.
• Percentage of discharges where member’s inpatient records were forwarded to an outpatient provider.
• Percentage of admissions where records were obtained of the member’s treatment history. This would only be applicable where the member was in treatment at the time of admission.
• Percentage of discharges where the member had at least 1 follow-up appointment within 7 days of discharge and/or 2 visits within 30 days of discharge.
• Percentage of patients with Major Depressive Disorder who attend 75% of weekly follow-up appointments for 12 weeks post-inpatient discharge.

L. REFERENCES


psychodynamic-interpersonal psychotherapy. *Archive of General Psychiatry, 47*(12), 1093-1099.


## Appendix I: Federal EQR Standard Compliance Addressed in the 2013 BBA Technical Reports Evaluated by OMHSAS

### SECTION I: MANDATORY REGULATORY REQUIREMENTS

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>DESCRIPTION</th>
<th>Community Behavioral Health (CBH) (Addressed on technical report page (s))</th>
<th>Community Care Behavioral Health (Addressed on technical report page (s))</th>
<th>Magellan Behavioral Health (MBH) (Addressed on technical report page (s))</th>
<th>PerformCare (PC) (Addressed on technical report page (s))</th>
<th>Value Behavioral Health (VBH) (Addressed on technical report page (s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.364(a)(2)</td>
<td>The technical report includes an assessment of each MCOs’ and PIHPs’ strengths and weaknesses with respect to quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.</td>
<td>47-53</td>
<td>50-54</td>
<td>48-53</td>
<td>64-68</td>
<td>46-50</td>
</tr>
<tr>
<td>§438.364(a)(3)</td>
<td>The technical report includes recommendations for improving quality of health care services furnished by each MCO or PIHP.</td>
<td>47-48</td>
<td>50</td>
<td>48</td>
<td>64</td>
<td>46</td>
</tr>
</tbody>
</table>
| §438.364(a)(4)      | The technical report includes methodologically appropriate, comparative information for all MCOs/PIHPs.  
This information should align with what the state outlines in its quality strategy as methodologically appropriate | 26-34 | 29-46 | 25-34 | 26-37 | 28-39 |
| §438.364(a)(5)      | The technical report includes an assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the External Quality Review Organization (EQRO) during the previous year’s EQR.  
If there were no prior year recommendations, this requirement is not applicable. | 35-46 | 47-49 | 36-47 | 38-63 | 40-45 |
| §438.364(b)         | The information included in the technical report is readily available through print or electronic media.  
It must be available for persons with sensory impairments, when requested. | Technical reports are found online at: [http://www.DHS.state.pa.us/publications/healthchoicesbehavioralhealthpublications/index.htm](http://www.DHS.state.pa.us/publications/healthchoicesbehavioralhealthpublications/index.htm) |
| §438.364(c)         | The information included in the technical report does not disclose the identity of any patient. | There is no specific information on any pages of the reports. |
## SECTION II: MANDATORY FOR ACTIVITIES

### Validation of Performance Improvement Projects (PIPs)

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>DESCRIPTION</th>
<th>CBH (Addressed on technical report page(s))</th>
<th>CCBHO (Addressed on technical report page(s))</th>
<th>MBH (Addressed on technical report page(s))</th>
<th>PC (Addressed on technical report page(s))</th>
<th>VBH (Addressed on technical report page(s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.358(b)(1)</td>
<td>The technical report includes information on the validation of PIPS required by the state to comply with requirements set for in § 438.240(b)(1) and that were underway during the preceding 12 months.</td>
<td>15-21</td>
<td>19-24</td>
<td>15-20</td>
<td>16-21</td>
<td>18-23</td>
</tr>
<tr>
<td>§438.364(a)(1)</td>
<td>The technical report describes the manner in which the data from the validation of PIPs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.</td>
<td>15-21</td>
<td>19-24</td>
<td>15-20</td>
<td>16-21</td>
<td>18-23</td>
</tr>
</tbody>
</table>
| §438.364(a)(1) (i-iv) | The technical report includes the following related to the validation of PIPs:  
   - Objectives:  
     Methods of data collection and analysis (Note: this should include a description of the of validation process/methodology, e.g., was the CMS PIP validation protocol used, or a method consistent with the CMS protocol);  
     Description of data obtained; and  
     Conclusions drawn from the data. | 15-21 | 19-24 | 15-20 | 16-21 | 18-23 |
| §438.358(b)(1)       | The technical report includes validations results for all state-required PIP topics for the current EQR review cycle. | 17-21 | 21-24 | 17-20 | 18-21 | 20-23 |
Validation of Performance Measures (PMs)

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>DESCRIPTION</th>
<th>CBH (Addressed on technical report page (s))</th>
<th>CCBHO (Addressed on technical report page (s))</th>
<th>MBH (Addressed on technical report page (s))</th>
<th>PC (Addressed on technical report page (s))</th>
<th>VBH (Addressed on technical report page (s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.358(b)(2)</td>
<td>The technical report includes information on the validation of MCO or PIHP PMs reported (as required by the state) or MCO or PIHP PMs calculated by the state during the preceding 12 months to comply with requirements set forth in § 438.240(b)(2).</td>
<td>22-34</td>
<td>25-46</td>
<td>21-35</td>
<td>22-37</td>
<td>24-39</td>
</tr>
<tr>
<td>§438.364(a)(1)</td>
<td>The technical report describes the manner in which the data from the validation of PMs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.</td>
<td>22-34</td>
<td>25-46</td>
<td>21-35</td>
<td>22-37</td>
<td>24-39</td>
</tr>
</tbody>
</table>
| §438.364(a)(1)(i-iv) | The technical report includes the following related to the validation of PMs:  
  - Objectives:  
    Methods of data collection and analysis (Note: this should include a description of the of validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol);  
    Description of data obtained; and  
    Conclusions drawn from the data.  
  - Validation:  
    5-6, 2013 Encounter Data Onsite PM Review  
    5-6, 2013 Encounter Data Onsite PM Review  
    5-6, 2013 Encounter Data Onsite PM Review  
    5-6, 2013 Encounter Data Onsite PM Review  
    5-6, 2013 Encounter Data Onsite PM Review | 22-34 | 25-46 | 21-35 | 22-37 | 24-39 |
| §438.358(b)(2)       | The technical report includes validation results of PMs for each MCO/PIHP for the current EQR review cycle. | 26-28 | 29-32 | 25-26 | 26-27 | 28-29 |
|                      |             | 33   | 35-37 | 28   | 39-30 | 32   |
|                      |             |      | 43-44 | 33   | 34-35 | 37-38 |
## Compliance Review

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>DESCRIPTION</th>
<th>CBH (Addressed on technical report page(s))</th>
<th>CCBHO (Addressed on technical report page(s))</th>
<th>MBH (Addressed on technical report page(s))</th>
<th>PC (Addressed on technical report page(s))</th>
<th>VBH (Addressed on technical report page(s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.358(b)(3)</td>
<td>The technical report includes information on a review, conducted within the previous 3-year period, to determine the MCOs' or PIHPs' compliance with standards (except with respect to standards under §§ 438.240(b)(1) and (2), for the conduct of PIPS and calculation of PMs respectively) established by the state to comply with the requirements of § 438.204(g). NOTE: This may be done once every three years, or partially deemed as per § 438.360. If partially deemed, the state must identify in its quality strategy the standards for which the EQR will use information from Medicare or private accreditation reviews, and explains the rationale for why the standards are duplicative.</td>
<td>5-14</td>
<td>5-18</td>
<td>5-14</td>
<td>5-15</td>
<td>5-17</td>
</tr>
<tr>
<td>§438.364(a)(1)</td>
<td>The technical report describes the manner in which the data from the compliance review were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.</td>
<td>5-14</td>
<td>5-18</td>
<td>5-14</td>
<td>5-15</td>
<td>5-17</td>
</tr>
</tbody>
</table>
| §438.364(a)(1) (i-iv)| The technical report includes the following related to the validation of PMs:  
- Objectives:  
  Methods of data collection and analysis (Note: this should include a description of the of validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol);  
- Description of data obtained; and  
- Conclusions drawn from the data. | 5-14 | 5-18 | 5-14 | 5-15 | 5-17 |
The technical report includes compliance assessment results for each MC/PIHP from within the past three years.

**SECTION III: OPTIONAL EQR ACTIVITIES**

The following are all optional EQR activities, and thus only applicable to the states which contract with their EQRO to perform such activities.

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>DESCRIPTION</th>
<th>CBH (Addressed on technical report page(s))</th>
<th>CCBHO (Addressed on technical report page(s))</th>
<th>MBH (Addressed on technical report page(s))</th>
<th>PC (Addressed on technical report page(s))</th>
<th>VBH (Addressed on technical report page(s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.364(a)(1) (i-iv)</td>
<td>If state contracts with the EQRO to validate encounter data (as described in § 438.358(c)(1)), the technical report must include the following related to that EQR activity: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.</td>
<td>Encounter Data Onsite Validation Report: 4-16</td>
<td>Encounter Data Onsite Validation Report: 4-16</td>
<td>Encounter Data Onsite Validation Report: 4-16</td>
<td>Encounter Data Onsite Validation Report: 4-16</td>
<td>Encounter Data Onsite Validation Report: 4-16</td>
</tr>
<tr>
<td>§438.364(a)(1) (i-iv)</td>
<td>If state contracts with the EQRO to administer or validate beneficiary or provider surveys of quality of care (as described in § 438.358(c)(2)), the technical report must include the following related to that EQR activity: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.</td>
<td>Not contracted with EQRO</td>
<td>Not contracted with EQRO</td>
<td>Not contracted with EQRO</td>
<td>Not contracted with EQRO</td>
<td>Not contracted with EQRO</td>
</tr>
</tbody>
</table>
§438.364(a)(1) (i-iv)  
Will be added in 2014  

If state contracts with the EQRO to calculate PMs in addition to those reported by an MCO or PHIP and validated by an EQRO (as described in § 438.358(c)(3)), the technical report must include the following related to that EQR activity:
- Objectives;
- Methods of data collection and analysis;
- Description of data obtained; and
- Conclusions drawn from the data.

<table>
<thead>
<tr>
<th>CBH (Addressed on technical report page(s))</th>
<th>CCBHO (Addressed on technical report page(s))</th>
<th>MBH (Addressed on technical report page(s))</th>
<th>PC (Addressed on technical report page(s))</th>
<th>VBH (Addressed on technical report page(s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not present</td>
<td>Not present</td>
<td>Not present</td>
<td>Not present</td>
<td>Not present</td>
</tr>
</tbody>
</table>

§438.364(a)(1) (i-iv)  

If state contracts with the EQRO to conduct PIPs in addition to those calculated by an MCO or PIHP and validated by an EQRO (as described in § 438.358(c)(4)), the technical report must include the following related to that EQR activity:
- Objectives;
- Methods of data collection and analysis;
- Description of data obtained; and
- Conclusions drawn from the data.

<table>
<thead>
<tr>
<th>CBH (Addressed on technical report page(s))</th>
<th>CCBHO (Addressed on technical report page(s))</th>
<th>MBH (Addressed on technical report page(s))</th>
<th>PC (Addressed on technical report page(s))</th>
<th>VBH (Addressed on technical report page(s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not contracted</td>
<td>Not contracted</td>
<td>Not contracted</td>
<td>Not contracted</td>
<td>Not contracted</td>
</tr>
</tbody>
</table>

§438.364(a)(1) (i-iv)  

Done in CY 2013 will be added in 2014 EQR Technical report  

If state contracts with the EQRO to conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time (as described in § 438.358(c)(5)), the technical report must include the following related to that EQR activity:
- Objectives;
- Methods of data collection and analysis;
- Description of data obtained; and
- Conclusions drawn from the data.

<table>
<thead>
<tr>
<th>CBH (Addressed on technical report page(s))</th>
<th>CCBHO (Addressed on technical report page(s))</th>
<th>MBH (Addressed on technical report page(s))</th>
<th>PC (Addressed on technical report page(s))</th>
<th>VBH (Addressed on technical report page(s))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not present BH readmission study</td>
<td>Not present BH readmission study</td>
<td>Not present BH readmission study</td>
<td>Not present BH readmission study</td>
<td>Not present BH readmission study</td>
</tr>
<tr>
<td>PH &amp; PH readmission study</td>
<td>PH &amp; PH readmission study</td>
<td>PH &amp; PH readmission study</td>
<td>PH &amp; PH readmission study</td>
<td>PH &amp; PH readmission study</td>
</tr>
</tbody>
</table>
Appendix J: SUMMARY RESULTS FROM THE 2013 ADULT CONSUMER AND FAMILY MEMBER PERCEPTION OF CARE SURVEYS (PA-MHSIP)

<table>
<thead>
<tr>
<th>ADULT CONSUMER Survey Results:</th>
<th>Number of Positive Responses</th>
<th>Responses</th>
<th>Confidence Interval*</th>
<th>Satisfaction Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reporting Positively About Access.</td>
<td>1,595</td>
<td>1,899</td>
<td>95</td>
<td>84%</td>
</tr>
<tr>
<td>2. Reporting Positively About Quality and Appropriateness for Adults.</td>
<td>1,542</td>
<td>1,899</td>
<td>95</td>
<td>81%</td>
</tr>
<tr>
<td>3. Reporting Positively About Outcomes.</td>
<td>1,116</td>
<td>1,899</td>
<td>95</td>
<td>59%</td>
</tr>
<tr>
<td>4. Adults Reporting on Participation In Treatment Planning.</td>
<td>1,518</td>
<td>1,899</td>
<td>95</td>
<td>80%</td>
</tr>
<tr>
<td>5. Adults Positively about General Satisfaction with Services.</td>
<td>1,578</td>
<td>1,899</td>
<td>95</td>
<td>83%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAMILY MEMBER of Child/Adolescent Consumer Survey Results:</th>
<th>Number of Positive Responses</th>
<th>Responses</th>
<th>Confidence Interval*</th>
<th>Satisfaction Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reporting Positively About Access.</td>
<td>1,011</td>
<td>1,164</td>
<td>95</td>
<td>87%</td>
</tr>
<tr>
<td>2. Reporting Positively about General Satisfaction for Children.</td>
<td>937</td>
<td>1,164</td>
<td>95</td>
<td>80%</td>
</tr>
<tr>
<td>3. Reporting Positively about Outcomes for Children.</td>
<td>735</td>
<td>1,164</td>
<td>95</td>
<td>63%</td>
</tr>
<tr>
<td>4. Family Members Reporting on Participation In Treatment Planning for their Children.</td>
<td>1,055</td>
<td>1,164</td>
<td>95</td>
<td>91%</td>
</tr>
<tr>
<td>5. Family Members Reporting High Cultural Sensitivity of Staff.</td>
<td>1,094</td>
<td>1,164</td>
<td>95</td>
<td>94%</td>
</tr>
</tbody>
</table>
### Appendix K: HealthChoices Behavioral Health Data Reporting Requirements (Non-Financial) (Appendix M from the HCBH PS&R)

<table>
<thead>
<tr>
<th>File/Report Name</th>
<th>Description</th>
<th>Frequency</th>
<th>Data Format Transfer Mode Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Monitoring</td>
<td>Reports on data needed for OMHSAS monitoring of the transition to a new contractor or subcontractor.</td>
<td>Weekly, during start-up or transition to a new BH-MCO. Time-limited.</td>
<td>File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due by close-of-business on Wednesday following the reporting week.</td>
</tr>
<tr>
<td>Quarterly Monitoring</td>
<td>Reports on data needed for ongoing monitoring of the HealthChoices Behavioral Health contract.</td>
<td>Quarterly</td>
<td>File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 45 days after the end of the reporting quarter.</td>
</tr>
<tr>
<td>837 Transactions</td>
<td>Reports each time a beneficiary has an encounter with a provider. Format/data based on HIPAA compliant 837 format.</td>
<td>Monthly (or more frequently, as scheduled by submitter)</td>
<td>File transfer via Secure eGOV data exchange. Each encounter record is due by the last calendar day of third month after the primary contractor paid/adjudicated the claim/encounter.</td>
</tr>
<tr>
<td>Alternative Payment Arrangement (APA) reporting</td>
<td>Reports any payment arrangement with a provider other than Fee-For-Service.</td>
<td>Varies</td>
<td>File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 30 days after the end of a payment cycle.</td>
</tr>
<tr>
<td>Complaints and Grievances</td>
<td>Reports aggregate data on complaints, grievances and resolutions. Also includes detail records on grievances.</td>
<td>Monthly</td>
<td>File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 30 days after the end of the reporting month.</td>
</tr>
<tr>
<td>Consumer Data: Consumer Registry/Quarterly Status (included in Performance Outcome Management System)</td>
<td>Reports person-specific demographic/clinical data at registry and closure; i.e. birth date, priority group, service request date, independence of living. Reports status and outcome data on priority group beneficiaries, i.e. independence of living, voc/ed, residential moves.</td>
<td>Quarterly</td>
<td>ASCII files via eGovernment Secure Data Exchange; due 30 days after the end of the reporting quarter.</td>
</tr>
</tbody>
</table>
### HealthChoices Behavioral Health Data Reporting Requirements (Non-Financial)

<table>
<thead>
<tr>
<th>File/Report Name</th>
<th>Description</th>
<th>Frequency</th>
<th>Data Format Transfer Mode Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Provider File</td>
<td>Reports all providers within the network.</td>
<td>Monthly</td>
<td>File transfer via SeGOV data exchange. Due by the second Monday of the month.</td>
</tr>
<tr>
<td>Monthly BHRS Services Report</td>
<td>Report tracks Therapeutic Staff Support (TSS) hours and beneficiaries authorized and TSS hours and beneficiaries paid.</td>
<td>Monthly</td>
<td>File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 4 months after the authorization month.</td>
</tr>
<tr>
<td>Denial Log</td>
<td>Reports each time a requested service was denied, as well as any alternatives approved.</td>
<td>Monthly</td>
<td>File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 15 days after end of reporting month.</td>
</tr>
</tbody>
</table>

* Does not cover financial reporting requirements. The file specifications, formats, data elements, and reporting requirements are subject to change by the Department.

** Pennsylvania PROMISe Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania’s PROMISe system.
Appendix L: Behavioral Health Managed Care Organizations (BH-MCOs) Performance/Outcome Management System (POMS)

1. OVERVIEW

The POMS consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources (see attached table of outcome measures and data sources). The database, which is maintained and managed by the Department of Human Services, contains an extensive array of raw data concerning enrollees in the BH-MCOs. The primary purpose of the database is to serve as the basis for producing a set of performance measures/indicators. The Department will utilize the performance measures/indicators as its primary tool for continuously evaluating the effectiveness of the BH-MCO contractors in achieving a variety of systems level outcomes.

The POMS serves the following primary functions:

(1) Provides accountability for public funds expended through the Department’s capitation payments to the BH-MCO contractors.

(2) Provides a fair and objective evaluation of the BH-MCOs that the Department can use for implementing outcome oriented incentives and sanctions.

(3) Supports the Department and the BH-MCO contractors to implement a collaborative continuous Quality Improvement process.

B. DATA COLLECTION PROCESSES

Raw data concerning BH-MCO enrollees, obtained from a variety of sources, will be transmitted via batch file extracts to the POMS central database. The data will be linked and integrated for each BH-MCO enrollee based on unique identifiers. The integrated database will provide the basis for DHS to derive quantitative performance indicators/measures that reflect systems level outcomes achieved by each BH-MCO primary contractor. The primary data sources and data collection processes are as follows:

1. **BH-MCO Encounter Data** - BH-MCOs, through a process similar to what DHS required for the HealthChoices PH-MCOs, will submit data files on a regular schedule to DHS. The data will be edited and then loaded into DHS’ Enterprise Data Warehouse. The Office of Mental Health and Substance Abuse Services (OMHSAS) will, on a regular schedule, receive a file of all DHS accepted encounter records and will perform additional edits before loading to the POMS central database.

2. **Enrollee Eligibility and Demographic Data** - DHS will on a regular schedule move enrollee eligibility and demographic data from its Client Information System (CIS) into the Enterprise Data Warehouse. OMHSAS will subsequently pull a subset of
eligibility and demographic data elements via data file extracts into the POMS central database.

3. **Secondary Data** - OMHSAS will develop data exchange agreements with other state agencies, as feasible, to obtain regularly scheduled data file extracts that will be loaded into the POMS central database. Data exchanges with state agencies such as the Department of Corrections, State Police, and the Department of Education are under development.

4. **Consumer/Family Satisfaction Reports** - There will be standardized measures administered by the BH-MCO. A Co-occurring Disorder (COD) question must be included on the survey and a sampling of COD beneficiaries must be surveyed. The BH-MCO will submit reports of findings to the DHS. A survey will be conducted annually.

5. **BH-MCO Consumer Registry File** - BH-MCOs will maintain a computerized registry of their enrollees who have accessed behavioral health services. The registry is comprised of a minimum data set including clinical descriptions such as priority population and critical dates during the episode of care such as date of first service request, registration date and termination date. These data will be submitted by the BH-MCOs to the POMS central database.

6. **BH-MCO Quarterly Status File** - BH-MCOs will maintain a computerized file concerning the status of priority populations. The file will be updated on a calendar quarter basis for each enrollee in the priority population. The quarterly status file is comprised of a minimum data set including outcome measures such as vocational/educational status and independence of living arrangement. These data will be submitted by the BH-MCOs to the POMS central database on a regular schedule.

7. **Performance Indicator Reports** - On a regular schedule, DHS will produce from the POMS central database a set of performance indicators that measure the performance of each BH-MCO consistent with the outcome dimensions outlined in the attached table of outcome measures. The performance indicator reports will be issued by DHS on a regular schedule to all relevant DHS monitoring staff, the BH-MCOs and other stakeholder groups.

C. **CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS**

The Department encourages the BH-MCOs to implement a Continuous Quality Improvement (CQI) process based upon Deming’s 14-point program for managed care adapted to the health care industry, and Joint Commission on Accreditation of Health Care Organization (JCAHO) guidelines. The overall process should include:

- Delineating the scope of the services to be monitored and improved.
- Identifying the important aspects of the services whose quality should be examined and improved.

- Identifying indicators (including but not limited to the performance indicators established by DHS) that will be used to monitor the quality, accessibility and appropriateness of the important aspects of services.

- Establishing thresholds (including but not limited to the thresholds established by DHS) for the review of indicators that become “flags” signaling the need for further analysis of the causes for the data reported to DHS.

Collecting data pertaining to each indicator and comparing the aggregate level of performance with the threshold for analysis. If the threshold is not reached, further analysis may not be necessary.

- Initiating analyses of other important aspects of services when thresholds have been reached.

- Taking actions to improve the aspects of services.

- Reporting the findings to the organizations involved, including a report of findings to DHS on a regular schedule. Monitoring and analysis are continued in order to identify any future deficiencies in services and to improve quality.

DHS monitoring staff will review the CQI reports of findings submitted by the BH-MCOs. DHS monitoring staff will provide feedback to BH-MCOs indicating:

1. Concurrence with the BH-MCOs explanation/cause of the performance indicator findings and actions proposed by the BH-MCOs to improve performance (and/or correct deficiencies).

2. Offer alternative explanations/causes for the performance indicator findings and/or recommended alternative actions to improve performance (and/or correct deficiencies).
APPENDIX M: QUALITY MANAGEMENT & UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

The Department will monitor the Quality Management (QM) and Utilization Management (UM) programs of all CHC-MCOs and retains the right of advance written approval of all QM and UM activities. The CHC-MCO’s QM and UM programs must incorporate all the requirements outlined in this Agreement and must be designed to assure and improve the accessibility, availability, and quality of care and services being provided to its participants. The CHC-MCO’s QM and UM programs must, at a minimum:

A. Contain a written program description, work plan, evaluation, and policies/procedures that meet requirements outlined in the agreement.

B. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the CHC-MCO in collaboration with the Department.

C. Be based on statistically valid clinical and financial analysis of Encounter Data, Participant demographic information, HEDIS®, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and services and racial/ethnic disparities to be targeted for quality improvement, case and disease management initiatives.

D. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations.

E. Submit all reports on data elements and quality measures as required and in the manner to be required by the Department.

F. Demonstrate sustained improvement for clinical performance over time.

G. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS® and CAHPS as outlined in Exhibit K(4), Healthcare Effectiveness Data and Information Set (HEDIS®).

H. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the CHC-MCO or the Department that:

1) Allow for the tracking and trending of issues on an aggregate basis pertaining to patterns of care and services.

2) Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the CHC-MCO to comply with the requirements and improvement actions requested by the Department may
result in the application of penalties and/or sanctions as outlined in Section VIII.H, Sanctions, of the Agreement.

I. Obtain accreditation by a nationally recognized organization, such as National Committee of Quality Assurance (NCQA).

J. Comply with National Quality Forum or other LTSS quality requirements as designated by the Department.

**Standard I:** The scope of the QM and UM programs must be comprehensive in nature; allow for improvement and be consistent with the Department’s goals related to access, availability, and quality of care and services. At a minimum, the CHC-MCO’s QM and UM programs, must:

A. Adhere to current Medicaid CMS guidelines.

B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review.

C. Ensure that that all QM and UM activities and initiatives undertaken by the CHC-MCO are based upon clinical and financial analysis of Encounter Data, Participant demographic information, HEDIS®, CAHPS, Pennsylvania Performance Measures and/or other identified areas.

D. Contain policies and procedures which provide for the ongoing review of the entire scope of care and services provided by the CHC-MCO assuring that all demographic groups, races, ethnicities, disabilities, care and service settings and types and models of services are addressed.

E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the CHC-MCO’s QM and UM programs. The written program description must, at a minimum:

1) Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, and Participant services in accordance with timeframes outlined in Exhibit BB, Provider Network Composition/Service Access of the Agreement.

2) Distinct policies and procedures regarding how Service Coordinators will authorize LTSS and communicate those authorizations to providers.

3) Include mechanisms for planned assessment and analysis of the quality of care and services provided and the utilization of services against formalized standards, including but not limited to:
a) Primary, secondary, and tertiary care.
b) Preventive care and wellness programs.
c) Acute and/or chronic conditions.
d) Emergency Department utilization and ED diversion efforts.
e) Dental care.
f) LTSS.
g) Service Coordination.
h) Continuity of care.

4) Allow for the timely, accurate, complete collection, and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS®, CAHPS, and Pennsylvania Performance Measures.

5) Allow for systematic analysis and re-measurement of barriers to care and services, the quality of care and services provided to participants, and utilization of services over time.

F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities including, but not limited to:

a) Studies and activities undertaken; including the rationale, methodology, and results.
b) Subsequent improvement actions.
c) Aggregate clinical and financial analysis of Encounter, HEDIS®, CAHPS, Pennsylvania Performance Measures, and other data on the quality of care rendered to participants and utilization of services.

G. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, including, but not limited to:

1) Data collection and analysis.
2) Evaluation and reporting of findings.
3) Implementation of improvement actions where applicable.
4) Individual accountability for each activity.

H. Provide for aggregate and individual analysis and feedback of Provider performance and CHC-MCO performance in improving access to Covered Services, the quality of care and services provided to participants and utilization of Covered Services.

I. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM and UM programs are integrated into activities and initiatives undertaken by other departments within the CHC-MCO including, but not limited to, the following:
1) Provider Relations.
2) Participant Services.
3) Management Information Systems.

J. Include procedures for informing both physician and non-physician Providers about the written QM and UM programs, and for securing cooperation with the QM and UM programs in all physician and non-physician Provider agreements.

K. Include procedures for feedback and interpretation of findings from analysis of quality and utilization data to Providers, health professionals, CHC-MCO staff, and Medical Assistance beneficiaries/family members.

L. Include mechanisms and processes which allow for the development and implementation of CHC-MCO wide and Provider specific improvement actions in response to identified barriers to care and services, quality of care and services concerns, and over-utilization, under-utilization and/or mis-utilization of services.

M. The CHC-MCO shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures.

- Pre-admission certification process for non-emergency admissions;
- A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CHC-MCO shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a Participant can be transferred to a contract facility in the network, if presently in a non-contract facility;
- Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;
- Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and
- Prospective review of same day surgery procedures.

N. The CHC-MCO shall ensure that reimbursement of nursing facility care is provided for participants who have been determined to be eligible for reimbursement of nursing facility care for the period specified. The CHC-MCO shall monitor the Participant’s condition for ongoing care and potential discharge back to community living.
O. The CHC-MCO shall utilize the following guidelines in identifying and managing care for participants who are determined to have excessive and/or inappropriate ED utilization:

- Review ED utilization data, at a minimum, every six (6) months to identify participants with utilization exceeding the threshold defined as six (6) or more visits in the defined six (6) month period (January through June and July through December);
- For participants whose utilization exceeds the threshold of ED visits defined above in the previous six (6) month period, the CHC-MCO shall conduct appropriate follow-up to identify the issues causing frequent ED utilization and determine appropriate next steps.
- As appropriate, make contact with participants whose utilization exceeded the threshold of ED visits in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization.
- Assess the most likely cause of high utilization and develop a PCSP based on results of the assessment for each Participant.

P. The CHC-MCO shall comply with any applicable federal and state laws or rules related to length of hospital stay.

Q. In addition to meeting the reporting requirement for oversight and monitoring of the program, the CHC-MCO must report all information required for early implementation evaluation, as outlined by the Department. The CHC-MCO must also comply with all implementation monitoring and oversight requirements. The CHC-MCO must comply with any program policy changes resulting from the Department’s rapid cycle, implementation monitoring, or other evaluation of the CHC Program.

**Standard II: The organizational structures of the CHC-MCO must ensure that:**

A. The Governing Body:

1) Has formally designated an accountable entity or entities, within the CHC-MCO to provide oversight of QM and UM program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.

2) Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken. The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS®, CAHPS, and Pennsylvania Performance Measures.
3) Documents actions taken by the governing body in response to findings from QM and UM program activities.

B. The Quality Management Committee (QMC):

1) Must contain policies and procedures which describe the role, structure and function of the QMC that:

   a) Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM and UM program activities;

   b) Ensure membership on the QMC and active participation by individuals representative of the composition of the CHC-MCO’s Providers; and

   c) Provide for documentation of the QMC’s activities, findings, recommendations, and actions.

2) Meets at least monthly, and otherwise as needed.

C. The Director of LTSS ensures the provision of LTSS in home and community-based settings is provided in accordance with the requirements outlined in this Agreement and the CHC 1915(c) Waiver.

D. The Director of Quality Management serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives.

E. The Senior Medical Director must be directly accountable to and act as liaison to the Chief Medical Officer for DHS.

F. The Medical Director:

   1) Is available to the CHC-MCO’s medical staff for consultation on referrals, denials, Complaints and problems;

   2) Is directly involved in the CHC-MCO’s recruiting and credentialing activities;

   3) Is familiar with local standards of medical practice and nationally accepted standards of practice, including those for LTSS and with "most integrated setting" requirements under the ADA;

   4) Has knowledge of due process procedures for resolving issues between Network Providers and the CHC-MCO administration, and between participants and the CHC-MCO, including those related to medical decision making and utilization review;
5) Is available to review, advise and take action on questionable hospital admissions, Medically Necessary days and all other medical care and medical cost issues;

6) Is directly involved in the CHC-MCO’s process for prior authorizing or denying services and is available to interact with Providers on denied authorizations;

7) Has knowledge of current peer review standards and techniques;

8) Has knowledge of risk management standards;

9) Is directly accountable for all Quality Management and Utilization Management activities and

10) Oversees and is accountable for:

   a) Referrals to the Department and appropriate agencies for cases involving quality of care and services that have adverse effects or outcomes; and

   b) The processes for potential Fraud and Abuse investigation, review, sanctioning and referral to the appropriate oversight agencies.

G. The CHC-MCO must have sufficient material resources, and staff with the appropriate education, experience and training, to effectively implement the written QM and UM programs and related activities.

**Standard III:** The QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to participants through quality of care studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

A. The QM and UM programs must include professionally developed practice guidelines/standards of care and services that are:

   1) Written in measurable and accepted professional formats,
   2) Based on scientific evidence; and
   3) Applicable to Providers for the delivery of certain types or aspects of health care or LTSS.

B. The QM and UM programs must include clinical/quality Indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.
C. Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO. The areas addressed must include, but are not limited to:

1) Adult preventive care;
2) LTSS;
3) Service Coordination provision;
4) Obstetrical care including a requirement that participants be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;
5) Selected diagnoses and procedures relevant to the enrolled population;
6) Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the CHC-MCO’s Participant; and Preventive dental care.

D. The QM and UM programs must provide practice guidelines, clinical indicators and medical record keeping standards to all Providers and appropriate subcontractors. This information must also be provided to participants upon request.

E. The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of ancillary services not less than every two years (i.e. medical record audits). These methodologies must, at a minimum:

1) Demonstrate the degree to which PCPs, specialists, and dental Providers are complying with clinical and preventive care guidelines adopted by the CHC-MCO;

2) Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO;

3) Allow for the tracking and trending of individual and CHC-MCO wide Provider performance over time;

4) Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care and services concerns, including events such as Health Care-Associated Infections, medical errors, and adverse patient outcomes; and

5) Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization;

F. The QM and UM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:
1) Processes that allow for the identification, investigation and resolution of quality of care and services concerns including Health Care-Associated Infections, medical errors, and adverse patient outcomes;

2) Processes for tracking and trending patterns of care and services;

3) Use of progressive sanctions as indicated;

4) Person(s) or body responsible for making the final determinations regarding quality problems; and

5) Types of actions to be taken, such as:
   a) Education;
   b) Follow-up monitoring and re-evaluation;
   c) Changes in processes, structures, forms;
   d) Informal counseling;
   e) Procedures for terminating the affiliation with the physician or other health professional or Provider;
   f) Assessment of the effectiveness of the actions taken; and
   g) Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and other inappropriate expenditures).

G. The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care and services concerns, Participant quality of care and services complaints, over-utilization, under-utilization, and/or mis-utilization, access/availability issues, and quality of care and services referrals from other sources;

H. The QM and UM programs must contain procedures for Participant satisfaction surveys that are conducted on at least an annual basis including the collection of annual Participant satisfaction data through application of the CAHPS instrument as outlined in Exhibit K(4), Healthcare Effectiveness Data and Information Set (HEDIS®). The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys and reserves the right to implement a CAHPS, CAHPS-like, or other survey at a later date.

I. The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, specialists, LTSS Providers, Nursing Facilities, Dental Providers, hospitals, and Providers of ancillary services.

J. Each CHC-MCO will be required to comply with requirements for Performance Improvement Projects (PIPs) as outlined in Exhibit K(2) External Quality Review.
K. The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS Service delivery.

**Standard IV:** The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to participants through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.

A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the participants of each PCP to the average utilization rates of all CHC-MCO participants. The CHC-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:

1) Utilization information on Participant Encounters with PCPs;
2) Specialty Claims;
3) Prescriptions;
4) Inpatient stays;
5) Nursing Facility use;
6) Community-based LTSS use;
7) Emergency room use; and
8) Clinical indicators for preventive care services (i.e., mammograms, immunizations, pap smear, etc.).

B. The CHC-MCO must have mechanisms and processes for profiling all Providers using risk adjusted diagnostic data for profiles.

C. The CHC-MCO must have mechanisms and processes for aggregate trending of changes to services, and reporting aggregate data to the Department.

D. The QM and UM programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care and services, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.

E. The QM and UM programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

**Standard V:** The CHC-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for participants identified. The
CHC-MCO must have a Complex Case Management Program and a Disease Management Program that must:

A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified participants.

B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.

C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.

D. Include performance indicators that allow for the objective measurement and analysis of individual and CHC-MCO wide performance in order to demonstrate progress made in improving access and quality of care and services.

E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym memberships and asthma camps.

**Standard VI:** The QM and UM programs must have mechanisms to ensure that participants receive seamless, continuous, and appropriate care and services throughout the continuum of care and services including transitions between care setting and coverage, by means of coordination of care and services, benefits, and quality improvement activities between:

A. PCPs and specialty care practitioners and other Providers;
B. Other CHC-MCOs;
C. The CHC-MCO and Medicare D-SNPs whether aligned or not aligned;
D. The CHC-MCO and Medicare FFS or Medicare Advantage;
E. The CHC-MCO and HealthChoices BH-MCOs;
F. The CHC-MCOs and Physical Health HealthChoices MCOs;
G. The CHC-MCO and the Department’s Fee-For-Service Program;
H. The CHC-MCO and other third party insurers;
I. The CHC-MCOs and LIFE providers;
J. The CHC-MCOs and Lottery funded services;
K. The CHC-MCOs and Hospitals or Nursing Facilities; and
L. The CHC-MCO and any other agency providing services to the Participant.

**Standard VII:** The CHC-MCO must demonstrate that it retains accountability for all QM and UM program functions, including those that are delegated to other entities.
The CHC-MCO must:

A. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the CHC-MCO.

B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care and services being provided.

C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM and UM program functions.

E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM and UM program functions undertaken by the entity on behalf of the CHC-MCO.

F. Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Participant.

**Standard VIII:** The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether all Providers, who provide health services or LTSS in the Commonwealth and are under contract to the CHC-MCO, are qualified to perform their services.

A. The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department’s requirements outlined in this Agreement and through the credentialing framework to be provided to plans. Recredentialing activities must be conducted by the CHC-MCO at least every five (5) years. Criteria must include, but not be limited to, the following as applicable to the Provider type:

1) Appropriate license or certification as required by Pennsylvania state law;

2) Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;
3) Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMISe™ Provider ID issued by the Department;

4) Evidence of malpractice/liability insurance;

5) A valid Drug Enforcement Agency (DEA) certification;

6) Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach;

7) Consideration of quality issues such as Participant Complaint and/or Participant satisfaction information, sentinel events and quality of care concerns.

B. For purposes of credentialing and recredentialing, the CHC-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the CHC-MCO does not meet the statutory requirements for accessing the NPDB, then the CHC-MCO must obtain information from the Federation of State Medical Boards

C. Appropriate PCP qualifications:

1) Seventy-five to 100% of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or geriatrics;

2) No more than 25% of the Network consists of PCPs without appropriate residencies but who have, within the past seven years, five years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or geriatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described; and

3) No more than 10% of the Network consists of PCPs who were previously trained as specialist physicians and changed their areas of practice to primary care, and who have completed Department-approved primary care retraining programs.

4) A PCP must have the ability to perform or directly supervise the ambulatory primary care services of participants;

5) Membership of the medical staff with admitting privileges of at least one general hospital or an acceptable arrangement with a PCP with admitting privileges;

6) Demonstrate evidence of continuing professional medical education;
7) Attend at least one CHC-MCO sponsored Provider education training session as outlined in Section V.BB.2, Provider Education, of the Agreement.

D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and

E. As part of the Provider release form, the potential Provider must agree to release all Medical Assistance records pertaining to sanctions and/or settlement to the CHC-MCO and the Department.

F. The Department will recoup from the CHC-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the CHC-MCO in a manner that is not consistent with the Provider's licensure. In addition, the CHC-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

G. The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices.

H. Any economic profiles used by the CHC-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Participant age, Participant sex, Provider case-mix and Participant severity. The CHC-MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.

I. In the event that a CHC-MCO renders an adverse credentialing decision, the CHC-MCO must provide the affected Provider with a written notice of the decision. The notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department.

J. The CHC-MCO must meet the following standards related to timeliness of processing new Provider applications for credentialing.

1) The CHC-MCO must begin its credentialing process upon receipt of a Provider's credentialing application if the application contains all required information.
2) The CHC-MCO may not delay processing the application if the Provider does not have an MAID number that is issued by the DHS. However, the CHC-MCO cannot complete its process until the Provider has received its MAID number from DHS.

3) Provider applications submitted to the CHC-MCO for credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.

**Standard IX:** The CHC-MCO’s written UM program must contain policies and procedures that describe the scope of the program, mechanisms, information sources used to make decisions on Covered Services and in conjunction with the requirements in Exhibit G Prior Authorization Guidelines for Participating Managed Care Organizations in the CHC Program.

A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review and coverage decisions on Covered Services.

B. A Person Centered Service Plan shall be developed and implemented for all NFCE participants and others who request or require Service Coordination. The CHC-MCO shall audit a Department-approved sample size sample of the PCSPs to demonstrate compliance with the requirements of the QM/UM program. The CHC-MCO must use a protocol to select the PCSPs that has been submitted to and reviewed by the Department. Audit results must be submitted to the Department as part of the Annual QAPI Program Evaluation.

C. The UM program must allow for coverage decisions about Covered Services that are consistent with the CHC Program definition of Medically Necessary found in Section II, Definitions and the requirements of the CHC 1915(c) Waiver.

Coverage decisions for Covered Services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The CHC-MCO shall base its determination on information provided by the Participant the Participant’s family/caretaker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Participant. Medical necessity determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

D. If the CHC-MCO wishes to require Prior Authorization of any services, they must establish and maintain written policies and procedures for the Prior Authorization review process as required under Section V.B., Prior Authorization of Services and Exhibit G of this Agreement.
E. The CHC-MCO must provide all Licensed Proprietary Products that they will use in evaluating medical necessity for medical services. Licensed Proprietary Products may include, but are not limited to: Interqual and Milliman. All Utilization Review Criteria and/or policies and procedures that contain Utilization Review Criteria used to determine medical necessity must:

1) Require definitions of medical necessity that are consistent with the CHC definition of Medically Necessary;

2) Make determinations of medical necessity that are consistent with the CHC Program definition of Medically Necessary;

3) Assess the individual’s current condition and response to treatment and/or co-morbidities, psychosocial, environmental and/or other needs that influences care and services;

4) Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;

5) Be developed using a scientific based process;

6) Be reviewed at least annually and updated as necessary; and

7) Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.

F. The CHC-MCO must ensure that Prior Authorization and Concurrent review decisions:

1) Are supervised by a physician or Health Care practitioner with appropriate clinical expertise in treating the Participant’s condition or disease;

2) That result in a denial may only be made by a licensed physician;

3) Are made in accordance with established time-frames outlined in the agreement for routine, urgent, or emergency care; and

4) Are made by clinical reviewers using the CHC definition of medical necessity.

G. The CHC-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, LTSS, and medical supplies. The CHC-MCO must have written policies and procedures that address how participants and providers can make contact with the CHC-MCO to receive instruction or Prior Authorization, as necessary.
H. Additional Prior Authorization requirements can be found in Exhibit G, Prior Authorization Guidelines for Participating Managed Care Organizations in the CHC Program.

I. The CHC-MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing Provider before issuing a denial based upon medical necessity.

J. The CHC-MCO must ensure that sources of utilization criteria are provided to participants and providers upon request.

K. The UM program must contain procedures for providing written notification to participants of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures must:

1) Meet requirements outlined in Exhibit T, Complaints, Grievances, and DHS Fair Hearing Process.

2) Provide for written notification to participants of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.

3) Include notification to participants of their right to file a Complaint, Grievance or DHS Fair Hearing as outlined in Exhibit T, Complaints, Grievances, and DHS Fair Hearing Process.

L. The CHC-MCO must agree to comply with the Department's quality monitoring and utilization review monitoring processes, including, but not limited to:

1) Submission of a log of all denials issued using formats to be specified by the Department.

2) Submission of denial notices for review as requested by the Department.

3) Submission of utilization review records and documentation as requested by the Department.

4) Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.

5) Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.
Standard X: The CHC-MCO must have a mechanism in place for Provider Appeals/Provider Disputes related to the following:

A. Administrative denials including denials of Claims/payment issues, and payment of Claims at an alternate level of care than what was provided, i.e. acute versus skilled days. This includes the appeal by Health Care Providers of a CHC-MCO’s decision to deny payment for services already rendered by the Provider to a Member.

B. QM/UM sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

Standard XI: The CHC-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals within the CHC-MCO for use in other management activities.

A. The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the CHC-MCO for use in conjunction with other related activities such as:

1) CHC-MCO Provider Network changes;
2) Benefit changes;
3) Medical management systems (e.g., pre-certification);
4) Practices feedback to Providers; and
5) Service Coordination or Service Planning changes.

Standard XII: The CHC-MCO must have written policies and procedures for conducting prospective and retrospective DUR that meet requirements outlined in Exhibit CC, Outpatient Drug (Pharmacy) Services.

Standard XIII: The CHC-MCO must have written standards for maintaining Comprehensive Medical and Service Record (including PCSPs) record keeping. The CHC-MCO must ensure that the Comprehensive Medical and Service Records contain written documentation of the medical necessity of a rendered, ordered or prescribed service.

A. The CHC-MCO must have written policies and procedures for the maintenance of Comprehensive Medical and Service Records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information.
Written policies and procedures for the CHC-MCO and its Network Providers must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

B. Medical record standards for the CHC-MCO and its Network Providers must meet or exceed medical record keeping requirements contained in 55 Pa. Code Section 1101.51(d)(e) of the Medical Assistance Manual and medical record keeping standards adopted by DOH.

C. Comprehensive Medical and Service Records must, at a minimum, include the following information to the extent related to CHC-MCO Covered Services or related to other services coordinated by the CHC-MCO but covered by a Participant’s Medicare or other source of coverage. The CHC-MCO record must include:

1) History and physical that is appropriate to the patient’s current condition.
2) Treatment plan, progress and changes in treatment plan.
3) Diagnostic tests and results.
4) Therapies and other prescribed regimens.
5) Disposition and follow-up.
6) Referrals and results thereof.
7) Hospitalizations.
8) Reports of operative procedures and excised tissues.
9) Medication record/PCSP, where applicable.
10) Services provided as per the PCSP for participants who have one.
11) Service Coordination contact notes.
12) All other aspects of patient care or Participant service delivery.

D. The CHC-MCO must have written policies and procedures to assess the content of Comprehensive Medical and Service Records for legibility, organization, completion and conformance to its standards.

E. The CHC-MCO must ensure access of the Participant to his/her Comprehensive Medical and Service Records at no charge and upon request.

F. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted or subcontracted with by the Department) shall be afforded prompt access to all Participants’ Comprehensive Medical and Service Records whether electronic or paper. All Comprehensive Medical and Service Records copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from a Participant before requesting the Participant’s Comprehensive Medical and Service Records from the CHC-MCO, PCP or any other agency.
H. Comprehensive Medical and Service Records must be preserved and maintained for a minimum of five years from expiration of the CHC-MCO’s contract. Comprehensive Medical and Service Records must be made available in paper form upon request.

I. When a Participant changes PCPs, the CHC-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within five business days from receipt of the request. In emergency situations, the CHC-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

J. When a Participant changes CHC-MCOs, the CHC-MCO must facilitate the transfer of his/her Comprehensive Medical and Service Records or copies of the Comprehensive Medical and Service Records to the new CHC-MCO within five business days from the effective date of enrollment in the gaining CHC-MCO. In emergency situations, the CHC-MCO must facilitate the transfer of Comprehensive Medical and Service Records as soon as possible from receipt of the request.

**Standard XIV:** The QM and UM program must demonstrate a commitment to ensuring that participants are treated in a manner that acknowledges their defined rights and responsibilities.

A. The CHC-MCO must have a written policy that recognizes the rights of participants outlined in this Agreement and Exhibit FF.

B. The CHC-MCO must have a written policy that addresses Participant’s responsibility for cooperating with those providing health care services. This written policy must address Participant’s responsibility for:

1) Providing, to the extent possible, information needed by professional staff in caring for the Member.

2) Following instructions and guidelines given by those providing health care services.

3) Participants shall be asked to provide consent to managed care plans, Health Care Providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, participants will remain anonymous to the greatest extent possible.

C. The CHC-MCO’s policies on Participant rights and responsibilities must be provided to all Network Providers.
D. Upon enrollment, participants must be provided with a written statement that includes information on the following:

1) Rights and responsibilities of participants as outlined in this Agreement and Exhibit FF.

2) A Participant Handbook fulfilling the Participant Handbook requirements of this Agreement.

3) All other items outlined in Section V.O. and requirements of that section for distribution to Participants upon Enrollment.

E. The CHC-MCO must have policies and procedures for resolving Participant Complaints and Grievances that meet all requirements outlined in Exhibit T, Complaints, Grievances, and DHS Fair Hearing Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care and services issues exists and for appropriate referral of identified issues.

F. Opportunity must be provided for participants to offer suggestions for changes in policies and procedures.

G. The CHC-MCO must take steps to promote accessibility of services offered to participants. These steps must include identification of the points of access to primary care, specialty care, LTSS, and hospital services. At a minimum, participants are given information about:

- How to obtain services during regular hours of operation;
- How to obtain after-hours, urgent and emergency care; and
- How to obtain the names, qualifications, and titles of the Health Care or LTSS Provider providing and/or responsible for their care.

H. Policies and procedures to ensure that Participant information (for example, Participant brochures, announcements, and handbooks) is provided in language that is readable and easily understood.

**Standard XV:** The CHC-MCO must maintain systems, which document implementation of the written QM and UM program descriptions.

A. The CHC-MCO must document that it is monitoring the quality of care and services across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.

B. The CHC-MCO must adhere to all systems requirements as outlined in Section V.X.5, Management Information Systems, and Section VIII.B,
Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the Intranet supporting CHC.

C. The CHC-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.

**Standard XVI:** The QM and UM systems must ensure timely, complete, regular needs assessments for participants who so require and must oversee development and implementation of PCSPs. They must also measure Participant satisfaction with quality of services, quality of life, experience of care, community integration, and quality of Service Coordination.

A. The CHC-MCO must document that it is monitoring the comprehensive needs assessment process across all populations. Comprehensive needs assessments must comply with the content and timeline requirements outlined in this Agreement and must be provided to the populations outlined in Section V.E.

B. The CHC-MCO must demonstrate that it is complying with its Department-approved service coordination staffing, communications, and Participant contact plan as required in this Agreement.

C. The CHC-MCO must demonstrate that participants who require it are provided person-centered service planning with input into who participates in their PCPTs and into the content of their PCSPs.

D. The CHC-MCO must demonstrate how PCSPs are implemented and how they are monitored to ensure that services outlined are being provided or coordinated across coverages, systems, or agencies.

E. The CHC-MCO must conduct annual Participant surveys using a survey tool approved by the Department to obtain feedback on quality of services, quality of life, experience of care, community integration, and quality of Service Coordination services provided.

1. One or all of the PIPs should be continued.
APPENDIX N: COMMUNITY HEALTHCHOICES PERFORMANCE MEASURES

The following are performance measures under consideration for the Community HealthChoices (CHC) program. Both final national and state measures will be refined following stakeholder input. OLTL’s goal is to select from each category performance measures that are most relevant to CHC participants.

SECTION 1 │ NATIONAL MEASURES
Indicators established by the Center for Medicare and Medicaid Services (CMS) and various national organizations include the following:

A. Healthcare Effectiveness Data and Information Set (HEDIS®)
B. CMS Medicaid Adult Core Measures
C. CMS Nursing Facility Measures
D. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
E. Medicare Measures for Dual-Eligible Special Needs Plans (D-SNPs)

SECTION 2 │ STATE MEASURES
Indicators established by the state to gauge performance, monitor compliance with state and federal regulations and guidelines, and ensure CHC participants are receiving good services in a timely manner.

A. Complaints, Denials, Appeals, Incidents, and Grievances
B. Long Term Services and Supports (LTSS) Community Based Services Measures
C. Service Coordination and Care Coordination
D. Nursing Facility Admissions/Discharges
E. CHC Waiver Assurances

SECTION 3 │ PROGRAM LAUNCH
Areas which will assist the state monitoring CHC during early implementation of each phase.

A. Continuity of Services and Service Coordination
B. LTSS Provider Network and Participation
### SECTION 1. NATIONAL MEASURES

The state will select national measures most relevant to the CHC participants from each of the following national sources.

<table>
<thead>
<tr>
<th></th>
<th>HEDIS® Performance Measures</th>
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<tbody>
<tr>
<td>A</td>
<td>Healthcare Effectiveness Data and Information Set (HEDIS®), a comprehensive set of standardized performance measures designed to provide consumers with information on health plan performance. More info: <a href="http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf">http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf</a></td>
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<tr>
<td></td>
<td>Data Source: MCO records and reports</td>
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<table>
<thead>
<tr>
<th></th>
<th>CMS Medicaid Adult Core Measures</th>
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<tbody>
<tr>
<td></td>
<td>Data Source: MCO records and reports, NCQA, and other sources</td>
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<thead>
<tr>
<th></th>
<th>CMS Nursing Facility Measures</th>
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<tbody>
<tr>
<td>C</td>
<td>CMS publishes a number of measures as part of their Nursing Home Quality Initiative. Pennsylvania will look at a selected number of these measures. More info: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html</a></td>
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<tr>
<td></td>
<td>Data Sources: MCO records and reports, MDS, NHT data</td>
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<tr>
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<th>CAHPS</th>
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<tbody>
<tr>
<td></td>
<td>Data Sources: MCO records and reports, MDS, NHT data</td>
</tr>
<tr>
<td>1</td>
<td>CAHPS: NH Long Stay Questionnaire</td>
</tr>
<tr>
<td>2</td>
<td>CAHPS: HCBS Questionnaire</td>
</tr>
<tr>
<td>3</td>
<td>CAHPS: Health Plan – Adult Medicaid Survey 5.0</td>
</tr>
</tbody>
</table>
**Medicare Measures for Dual-Eligible Special Needs Plans (D-SNPs)**

CMS is responsible for monitoring the quality of Medicare services. Pennsylvania’s MIPPA agreement requires D-SNPs to submit to the state all quality information it submits to CMS, enabling the state to monitor Medicare quality for CHC participants who are enrolled in companion D-SNPs.

Information required by CMS includes a selection of measures from Medicare HEDIS®, Medicare CAHPS, the Health Outcomes Survey and Part D measures developed by the Pharmacy Quality Alliance. Some measures are modified each year, and changes are outlined in the annual Medicare Advantage call letter.


| **Data Sources:** MCO records and reports, MDS, NHT data |

**SECTION 2. STATE MEASURES**

Few national measures are available for community-based LTSS. The state is defining measures in the following areas to address these national gaps.

**A | Complaints, Denials, Appeals, Incidents, and Grievances**

| Data Source: MCO reports, OLTL (Office of Long Term Living) reports |

| 1 | Numbers and types of complaints by MCO |
| 2 | Numbers and types of grievances by MCO |
| 3 | Appeals, Complaints, & Grievances Resolved Timely |
| 4 | Critical incidents reported and investigated Timely |
| 5 | Timely Issuance of Denial/Change Notices |
| 6 | Timely Determination of Prior Authorizations |

**B | Long Term Services and Supports (LTSS) Community Based Services Measures**

| Data Source: MCO records and reports |

<p>| 1 | LTSS members who used consumer-directed services by LTSS benefit types |
| 2 | New members meeting nursing facility (NF) level of care criteria who opt for HCBS |
| 3 | Completion of Person Centered Service Plan (PCSP) using protocols established in CHC agreement |
| 4 | PCSP documentation of member care goals and service needs |
| 5 | Members who have received Advance Planning Directives counseling |
| 6 | Newly admitted to NF w/out a discharge plan offered community supports and services |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>7</td>
<td>Members who are asked about employment-related needs during the PCSP process</td>
</tr>
<tr>
<td>8</td>
<td>Members who received employment-related waiver services</td>
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<tr>
<td>9</td>
<td>Members who are asked about housing-related needs during the PCSP process</td>
</tr>
<tr>
<td>10</td>
<td>Members who received assistance with housing-related needs</td>
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<tr>
<td>11</td>
<td>Members who were offered consumer-directed services</td>
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<tr>
<td>12</td>
<td>Difference in approved consumer-directed services on PCSP and utilized amount</td>
</tr>
<tr>
<td>13</td>
<td>Turnover of direct service workers and other workforce measures TBD</td>
</tr>
</tbody>
</table>

### C Service Coordination and Care Coordination

Data Source: MCO records and reports

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<table>
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<tbody>
<tr>
<td>1</td>
<td>Members to service coordination by risk group</td>
</tr>
<tr>
<td>2</td>
<td>Members received timely face-to-face assessment for LTSS services after non-emergency request</td>
</tr>
<tr>
<td>3</td>
<td>Members received timely authorization of non-emergency LTSS services after needs assessment</td>
</tr>
<tr>
<td>4</td>
<td>Members received timely non-emergency LTSS service after MCO authorization of services</td>
</tr>
<tr>
<td>5</td>
<td>Members received timely service coordinator assignment after member request</td>
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<td>6</td>
<td>Members who received timely face-to-face service coordination encounters</td>
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<td>7</td>
<td>Quarterly turnover rate for field service coordinators</td>
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<td>8</td>
<td>Service coordination hotline calls answered: by 4ᵗʰ ring and by live person</td>
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<td>9</td>
<td>Service coordination hotline: Number of Calls Abandoned</td>
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<td>10</td>
<td>Comprehensive Medication Review for all CHC population groups</td>
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<tr>
<td>11</td>
<td>Diagnostic and Treatment Review for all CHC population groups</td>
</tr>
<tr>
<td>12</td>
<td>Number of Members who MCO coordinates both Medicaid and Medicare services</td>
</tr>
<tr>
<td>13</td>
<td>Number of Members who MCO coordinates only Medicaid, while Medicare services are FFS</td>
</tr>
<tr>
<td>14</td>
<td>Number of members who MCO coordinates only Medicaid, while Medicare services are coordinated through a different MCO</td>
</tr>
<tr>
<td>15</td>
<td>Dual eligible Members for whom Medicaid and Medicare treatment recommendations conflict</td>
</tr>
<tr>
<td>16</td>
<td>Dual eligible Members for whom conflicting Medicare-Medicaid treatment recommendations are successfully resolved</td>
</tr>
<tr>
<td>17</td>
<td>Timeliness of PCSP completion</td>
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<tr>
<td>18</td>
<td>Members were offered a choice of where to receive LTSS services</td>
</tr>
<tr>
<td>19</td>
<td>PCSP includes planning for transition from NF to community and incorporates NF discharge plan</td>
</tr>
<tr>
<td>20</td>
<td>Members who appear on Section Q/FDIS MDS lists receive NHT information</td>
</tr>
<tr>
<td>21</td>
<td>Documented Reason why Members on Section Q/FDIS lists are not transitioned</td>
</tr>
</tbody>
</table>
## D Nursing Facility (NF) Admissions/Discharges

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Rate of admissions to NF from community</td>
</tr>
<tr>
<td>2</td>
<td>Rate of admissions to NF from hospital</td>
</tr>
<tr>
<td>3</td>
<td>Number of individuals who went from community to hospital to NF and remained in NF</td>
</tr>
<tr>
<td>4</td>
<td>Potentially Preventable Admissions (PPA) - Ratio of Actual to Expected (NF only)</td>
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<tr>
<td>5</td>
<td>Potentially Preventable Readmissions (PPR) - Ratio of Actual to Expected (NF only)</td>
</tr>
<tr>
<td>6</td>
<td>Rate of NF Discharges by RUG Group and/or Income Group</td>
</tr>
</tbody>
</table>

## E CHC Waiver Assurances

CHC waiver application can be found at [www.dhs.pa.gov](http://www.dhs.pa.gov)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>CHC-MCOs that meet contractual obligations</td>
</tr>
<tr>
<td>2</td>
<td>Clinical eligibility determinations (CEDs) completed timely by independent Assessment Entity</td>
</tr>
<tr>
<td>3</td>
<td>Contractual obligations met by the Outreach and Education vendor</td>
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<td>4</td>
<td>Contractual obligations met by the Independent Enrollment Broker</td>
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<td>5</td>
<td>Contractual obligations met by the Fiscal Employer Agent</td>
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<tr>
<td>6</td>
<td>Contractual obligations met by External Quality Review Organization</td>
</tr>
<tr>
<td>7</td>
<td>Participant distribution within the income limits applicable to the waiver</td>
</tr>
<tr>
<td>8</td>
<td>New enrollees had an initial CED that adhered to timeliness prior to receipt of waiver service</td>
</tr>
<tr>
<td>9</td>
<td>Completed applications in accordance with policies and procedures</td>
</tr>
<tr>
<td>10</td>
<td>Newly enrolled providers meet licensure and/or certification standards prior to service provision</td>
</tr>
<tr>
<td>11</td>
<td>Enrolled licensed/certified waiver providers continue to meet regulatory and applicable waiver standards</td>
</tr>
<tr>
<td>12</td>
<td>Newly enrolled non-licensed or non-certified providers meet regulatory and applicable waiver standards</td>
</tr>
<tr>
<td>13</td>
<td>Non-licensed or non-certified providers who continue to meet regulatory and applicable waiver standard</td>
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<tr>
<td>14</td>
<td>Providers meet provider training requirements</td>
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<tr>
<td>15</td>
<td>Participants who have PCSPs adequate and appropriate to their needs, capabilities, and desired outcomes</td>
</tr>
<tr>
<td>16</td>
<td>Participants with PCSPs reviewed before the waiver participant’s annual review date</td>
</tr>
<tr>
<td>17</td>
<td>Participants with PCSPs revised when warranted by a change in participant needs</td>
</tr>
<tr>
<td>18</td>
<td>Participants received services in the type, scope, amount, frequency and duration specified in the PCSPs</td>
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<tr>
<td>19</td>
<td>Participants had an opportunity for choice of waiver services and providers</td>
</tr>
<tr>
<td>20</td>
<td>Unexplained deaths for which review/investigation occurred</td>
</tr>
<tr>
<td>21</td>
<td>Number of complaints investigated within established procedures</td>
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<tr>
<td>22</td>
<td>Participant satisfaction survey respondents who reported a satisfaction score</td>
</tr>
<tr>
<td>23</td>
<td>Participants were informed of reporting process for abuse, neglect and exploitation in initial and annual reviews</td>
</tr>
<tr>
<td>24</td>
<td>Participants with more than three reported incidents within the past 12 months</td>
</tr>
<tr>
<td>25</td>
<td>Critical incidents reported and investigated within the prescribed timeframe</td>
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<tr>
<td>26</td>
<td>Incidents where restrictive interventions were used</td>
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<tr>
<td>27</td>
<td>Waiver participants receiving age-appropriate preventative health care</td>
</tr>
<tr>
<td>28</td>
<td>Capitation payments paid correctly in accordance with the methodology approved by CMS</td>
</tr>
<tr>
<td>29</td>
<td>Capitation payment rates that are consistent with approved rate methodology</td>
</tr>
</tbody>
</table>
### SECTION 3. PROGRAM LAUNCH

Listed below are areas which will assist the state in monitoring CHC during the launch when longer term data sources will not yet be available.

<table>
<thead>
<tr>
<th>A</th>
<th>CONTINUITY OF SERVICES AND SERVICE COORDINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Source: MCO records and reports, and reports from other vendors</td>
</tr>
<tr>
<td>1</td>
<td>Members are Enrolled and Receive LTSS Services Without Interruption</td>
</tr>
<tr>
<td></td>
<td>• Enrollment and disenrollment of members</td>
</tr>
<tr>
<td></td>
<td>• Members who received an HCBS service in the past week, at the procedure code level (aggregate)</td>
</tr>
<tr>
<td></td>
<td>• Members who received NF service in the past week</td>
</tr>
<tr>
<td></td>
<td>• Critical incidents in the past week</td>
</tr>
<tr>
<td></td>
<td>• Member complaints/grievances in the past week by reason/type of issue</td>
</tr>
<tr>
<td></td>
<td>• Member complaints/grievances trends in first 90 days</td>
</tr>
<tr>
<td>2</td>
<td>Service Coordination is Functioning Well</td>
</tr>
<tr>
<td></td>
<td>• Total LTSS members assigned to a service coordinator</td>
</tr>
<tr>
<td></td>
<td>• Total LTSS members who had a change in service coordinator</td>
</tr>
<tr>
<td></td>
<td>• Total LTSS members who received an in-person contact from a service coordinator in the past week</td>
</tr>
<tr>
<td></td>
<td>• Total LTSS members who received a phone contact from a service coordinator in the past week</td>
</tr>
<tr>
<td></td>
<td>• Total LTSS members who received a comprehensive needs assessment in the past week</td>
</tr>
<tr>
<td></td>
<td>• Total members who received a risk screening in the past week</td>
</tr>
<tr>
<td></td>
<td>• Number of risk screens in past week that indicated a need for comprehensive needs assessment</td>
</tr>
<tr>
<td></td>
<td>• Experience of service coordinators</td>
</tr>
<tr>
<td></td>
<td>• Experience of participants with service coordination</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>LTSS PROVIDER NETWORK AND PARTICIPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Source: MCO records and reports, and reports from other vendors</td>
</tr>
<tr>
<td>1</td>
<td>LTSS Providers Continue Delivering Services and are Paid Promptly</td>
</tr>
<tr>
<td></td>
<td>• Total claims received for HCBS in the past week, by provider type</td>
</tr>
<tr>
<td></td>
<td>• Total claims received for NF in the past week</td>
</tr>
<tr>
<td></td>
<td>• Unique HCBS providers with submitted claims in the past week</td>
</tr>
<tr>
<td></td>
<td>• Unique NFs with submitted claims in the past week</td>
</tr>
<tr>
<td></td>
<td>• Total HCBS claims paid, pending and rejected in the past week, by unique provider, type and reason</td>
</tr>
<tr>
<td></td>
<td>• Total NF claims paid, pending and rejected in the past week, by unique provider, type and reason</td>
</tr>
<tr>
<td></td>
<td>• Complaints/grievances filed by LTSS providers in the past month</td>
</tr>
<tr>
<td>2</td>
<td>Networks are Robust</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>LTSS providers with MCO contracts, and capacity of providers</td>
</tr>
<tr>
<td></td>
<td>Member complaints/grievances related to provider access in the past week</td>
</tr>
<tr>
<td></td>
<td>Member complaints/grievances related to provider access: trends in first 90 days</td>
</tr>
<tr>
<td></td>
<td>Network contracting experience</td>
</tr>
</tbody>
</table>

- Complaints/grievances filed by LTSS providers: trends in first 90 days
- Experience of LTSS providers during the transition
<table>
<thead>
<tr>
<th>NAME</th>
<th>PURPOSE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC-MCO Network Provider File</td>
<td>File provided listing all providers within the Network to serve participants.</td>
<td>Monthly</td>
</tr>
<tr>
<td>HCBS non-complaint settings</td>
<td>File provides list of settings where HCBS is provided that are non-compliant with 42 CFR Section 441.301(c)(4) and (5).</td>
<td>Quarterly</td>
</tr>
<tr>
<td>PCP File</td>
<td>File provides the PCP assignments for all participants.</td>
<td>Weekly</td>
</tr>
<tr>
<td>Automated Provider Directory File</td>
<td>File contains information on all providers in the Network for the CHC-MCO. The information will be used by the IEE for their Electronic (Online) Provider Directory.</td>
<td>Weekly</td>
</tr>
<tr>
<td>837P, 837I, 837D, NCPDP</td>
<td>HIPAA compliant file submitted by the CHC-MCO providing the Department with encounter data for all CHC-MCO participants.</td>
<td>As Scheduled</td>
</tr>
<tr>
<td>CHC/PH/BH Pharmacy File</td>
<td>Pharmacy data from the physical health plans to the behavioral health plans.</td>
<td>Submission based on schedule developed by the CHC-MCO (at least twice per month).</td>
</tr>
<tr>
<td>Weekly Enrollment/Alert File</td>
<td>File provided to notify the Department of return mail/changed address, newborns not in CIS, a participant's pregnancy not reflected in CIS, or a deceased participant with no date of death reflected in CIS.</td>
<td>Weekly</td>
</tr>
<tr>
<td>Complaints and Grievances</td>
<td>Reports aggregate data on complaints, grievances and resolutions. Also includes detail records on grievances.</td>
<td>As scheduled</td>
</tr>
<tr>
<td>Denial Log</td>
<td>Reports each time a requested service was denied, as well as any alternatives approved.</td>
<td>As scheduled</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Participant Files</td>
<td>Eligibility period, CHC-MCO coverage, Participant demographic information.</td>
<td>Monthly</td>
</tr>
<tr>
<td>PCSP change file</td>
<td>Reports aggregate data on PCSPs changes.</td>
<td>Weekly</td>
</tr>
<tr>
<td>HEDIS®, CAHPS adult and HCBS surveys</td>
<td>Report on the survey results of the HEDIS®, CAHPS adult survey and CAHPS HCBS survey.</td>
<td>Annually</td>
</tr>
<tr>
<td>Contract monitoring file</td>
<td>Reports on data needed for ongoing monitoring of the CHC HealthChoices contract (ex/Accreditation Report, Report of Services not covered, Report on Target Innovation Areas, SC staffing plan, Agreements with BH-MCOs, PCPT policy, health education activities, MCO organizational structure, subcontracts, data completeness plan, etc.)</td>
<td>As scheduled</td>
</tr>
</tbody>
</table>