Appendix Table 1. Inclusion of Aspects of Primary Care in State's Medicaid Managed Care Quality Strategy Plans

This table, which accompanies the *To the Point* post on state primary care quality strategies in Medicaid managed care, allows readers to view the extent to which any single state addresses key primary care-related quality strategy within its strategic plan, as well as the actual language used by the state in addressing any particular primary care strategy element.

State	Primary Care in Quality Strategy	Aspects of Primary Care						
		Access*	Comprehensiveness/ Social Determinants†	Care Coordination and Care Management‡	Patient and Caregiver Engagement§	Performance Improvement**	Cultural Competence††	Payment Reform Specific to Primary Care‡‡
Arizona	X		X[1]	X[2]			X[3]	
California	X		X[4]	X[5]	X[6]	X[7]	X[8]	
Colorado	X	X[9]	X[10]	X[11]	X[12]	X[13]	X[14]	X[15]
Dist. of Columbia								
Delaware	X	X[16]		X[17]	X[18]	X[19]	X[20]	
Florida	X	X[21]	X[22]	X[23]	X[24]	X[25]	X[26]	X[27]
Georgia	X	X[28]	X[29]	X[30]	X[31]	X[32]	X[33]	
Hawaii	X		X[34]	X[35]	X[36]	X[37]	X[38]	
Iowa	X		X[39]					
Illinois	X	X[40]	X[41]	X[42]	X[43]	X[44]	X[45]	X[46]
Indiana	X	X[47]	X[48]	X[49]	X[50]	X[51]	X[52]	
Kansas	X	X[53]	X[54]	X[55]		X[56]	X[57]	
Kentucky								
Louisiana	X	X[58]	X[59]	X[60]	X[61]	X[62]	X[63]	
Massachusetts	X		X[64]	X[65]	X[66]	X[67]	X[68]	X[69]
Maryland	X	X[70]	X[71]	X[72]	X[73]	X[74]	X[75]	
Michigan	X	X[76]	X[77]	X[78]	X[79]	X[80]	X[81]	X[82]
Minnesota	X	X[83]	X[84]	X[85]		X[86]	X[87]	X[88]
Missouri	X	X[89]	X[90]	X[91]	X[92]	X[93]	X[94]	
Mississippi	X	X[95]		X[96]	X[97]	X[98]	X[99]	
North Dakota	X	X[100]		X[101]	X[102]	X[103]	X[104]	
Nebraska	X	X[105]	X[106]	X[107]	X[108]	X[109]	X[110]	X[111]
New Hampshire	X	X[112]				X[113]	X[114]	
New Jersey	X	X[115]		X[116]	X[117]	X[118]	X[119]	X[120]
New Mexico	X	X[121]	X[122]	X[123]	X[124]	X[125]	X[126]	X[127]
New York	X	X[128]		X[129]	X[130]	X[131]	X[132]	
Nevada	X	X[133]		X[134]	X[135]	X[136]	X[137]	X[138]
Ohio	X	X[139]	X[140]	X[141]	X[142]	X[143]	X[144]	X[145]
Oregon§§	X	X[146]	X[146]	X[146]				X[146]

State	Primary Care in Quality Strategy	Aspects of Primary Care						
		Access*	Comprehensiveness/ Social Determinants†	Care Coordination and Care Management‡	Patient and Caregiver Engagement§	Performance Improvement**	Cultural Competence††	Payment Reform Specific to Primary Care‡‡
Pennsylvania	X	X[147]	X[148]	X[149]	X[150]	X[151]	X[152]	X[153]
Rhode Island	X	X[154]	X[155]	X[156]	X[157]	X[158]	X[159]	
South Carolina								
Tennessee	X	X[160]	X[161]	X[162]	X[163]	X[164]	X[165]	X[166]
Texas	X	X[167]		X[168]				X[169]
Utah	X	X[170]	X[171]	X[172]	X[173]	X[174]		
Virginia	X	X[175]	X[176]	X[177]	X[178]	X[179]	X[180]	
Washington	X	X[181]	X[182]	X[183]	X[184]	X[185]	X[186]	X[187]
Wisconsin	X	X[188]	X[189]	X[190]	X[191]		X[192]	
West Virginia	X	X[193]		X[194]	X[195]	X[196]		
Total	**36/39**	**31/39**	**27/39**	**34/39**	**29/39**	**31/39**	**31/39**	**16/39**

Notes: For the purposes of this analysis, we did not include references to citations for the Medicaid Managed Care Final Rule (81 Fed. Reg. 27498), but instead focused on components of the Quality Strategy Plans (QSPs) that exceed the minimum requirements set forth in the Final Rule in QSPs available as of September 1, 2018. All language included in footnotes is directly quoted from state QSPs unless otherwise noted. The District of Columbia, Kentucky, and South Carolina did not make their QSPs available at the time of the analysis.

* Access means provider availability, which includes alternatives to traditional office visits, time and distance standards, and appointment availability standards.

† Comprehensiveness means care delivery spanning the full breadth of the care spectrum (preventive, curative, and palliative); Social Determinants means care focused on patients outside the traditional clinical setting. This category includes preventative care services and collaboration of health-related social needs agencies (e.g., behavioral health, other agencies).

‡ Care Coordination and Care Management means patient-centered health care that is coordinated among different types of providers and settings and includes: team-based care; identification of high volume/cost specialists; short-term, targeted, and proactive relationship-based care management; ED visit and hospital follow-up; risk stratification processes for all empaneled patients; care plans for high-risk chronic disease patients; behavioral health integration; psychosocial needs assessment and inventory or resources and supports to meet psychosocial needs; and collaborative care agreements and development of practice capability to meet needs of high-risk populations.

§ Patient and Caregiver Engagement means activities that involve patients and families in care delivery and management processes, including patient and/or family advisory councils, assessment of practice capabilities to support patient self-management, patient self-management support for high-risk conditions and healthy behavior programs.

** Performance Improvement means the collection and use of data for process improvements, including review of payer utilization reports and practice electronic clinical quality measures data to inform improvement and care strategy for population health data.

†† Cultural Competence means methods to ensure inclusion. This category includes the provision of culturally competent materials and interpreters, the training and hiring of culturally competent staff, and the use of data to improve cultural competency.

‡‡ Payment Reform means strategies and methods to spur innovation to improve the primary care delivery system through changes to reimbursement and compensation, including pay-for-performance and value-based payments (e.g., alternative payment models) that incentivize clinicians to deliver high-quality and cost-efficient care.

§§ Instead of having one QSP like other states, Oregon's Medicaid program separates its QSP into 15 separately tailored Transformation and Quality Strategy Plans (TQSPs), one for each Coordinated Care Organization (CCO) in its Medicaid program. A CCO is a network of numerous types of health care providers (physical, mental and behavioral health) who have agreed to work together in specific localities to serve Medicaid beneficiaries. For specific language on each of Oregon's 15 TQSPs, please see https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx.

[1] The result is a managed care system that mainstreams recipients, allows them to select their providers, and encourages quality care and preventive services (p.7, Arizona 2018 Medicaid Managed Care Quality Strategy).

[2] On October 1, 2018, AHCCCS will implement new Managed Care Contracts that will be fully integrated products that offer both behavioral and physical healthcare services for the majority of the AHCCCS population. This integrated model will better meet the needs of AHCCCS members by establishing a single accountable plan that is responsible for partnering with providers to address the whole healthcare need of AHCCCS members (p. 7). Even with the establishment of the AHCCCS Complete Care Contracts on October 1, 2018 there will continue to remain important RBHA functions that are the responsibilities of AHCCCS Managed Care Organizations. These functions include: 1. Providing integrated services for Individuals with Serious Mental Illness (p. 8). The Department identifies establishing the American Indian Medical Home Program to provide care coordination services to members of this population as one of its strategies for its managed care program (p. 12). Other strategies include: At the contractor level, AHCCCS plans to offer an integrated contract for both behavioral and physical health services for all AHCCCS members by 2020; increasing the number of integrated providers in the system and plans to increase the number of integrated clinics available to members by 50% (p.13, Arizona 2018 Medicaid Managed Care Quality Strategy).

[3] We consult with, are culturally sensitive to and respond to the unique needs of each community we serve (p. 1). AHCCCS is establishing the American Indian Medical Home program to provide care coordination services to members of this Population (p. 12, Arizona 2018 Medicaid Managed Care Quality Strategy).

[4] The Department identifies the following managed care program goals. Maternal and child health: 1) Postpartum Care – increase the Medi-Cal weighted average for timely postpartum care to at least 64 percent for MY 2018) (p.44). Immunization of Two-Year-Olds – increase the proportion of beneficiaries with up-to-date immunizations by their second birthday; Chronic disease: 1) Hypertension – increase the proportion of beneficiaries with hypertension whose blood pressure is adequately controlled 2) Diabetes – decrease the proportion of beneficiaries with diabetes who had HbA1c testing greater than 9 percent or unknown, increase the proportion of beneficiaries with diabetes who had HbA1c testing 3) Tobacco Cessation – increase the median proportion of smokers who report being counseled to quit in the prior six months, increase the median proportion of smokers who report a provider discussed tobacco cessation medications in the prior six months (p. 11-15, California 2017 Medicaid Managed Care Quality Strategy Annual Assessment).

[5] The Department identifies treating the whole person by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care as one of its managed care program goals (p. 1, 17). Overall HDCS Quality Strategy Priorities: Enhance communication and coordination of care (p. 11). For the LTSS component of the CCI, all Medi-Cal members, including Duals, are required to join an MCP to receive Medi-Cal benefits, including LTSS and Medicare wrap-around benefits. MCPs are required to provide care coordination for these members. This includes risk-stratifying the population, conducting Health Risk Assessments (HRAs), when applicable or requested by the member, developing Individual Care Plans for high-risk members, and establishing Interdisciplinary Care Teams, when appropriate, or requested by the member (p. 21). The BHICCI aims to engage provider teams to test and implement fundamental practice changes in order to develop an array of "health homes" and integrated complex care management teams within local health organizations (p. 38). Intensive case management services are provided to these members during their stay, including all follow up medical, dental, behavioral health and social service appointments (p. 40). Through the BHICCI, IEHP provides funding to 12 healthcare organizations with 30 participating clinics to develop integrated, multidisciplinary care teams to care for the most complex patients served by these primary care, behavioral health, and specialty clinics. The complex care team manages and cares for a caseload of people with complex needs including co-occurring chronic medical, mental health, and/or substance use conditions, who also may be frequent utilizers of emergency room or inpatient services (p. 40). The PRIME program includes QIPs undertaken by Public Hospitals highlighting the following patient safety goals: ... Improve communication and coordination between inpatient and outpatient care teams to ensure continuity of health care as patients move from the hospital to the ambulatory care setting (p. 56-57). The Whole Person Care (WPC) pilot program is a five year, up to $1.5 billion federally funded pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes (p. 58). Effective January 1, 2014, MCPs are responsible to cover and pay for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition defined by the current Diagnostic and Statistical Manual of Mental Disorders. These services, described in APL 13-021, are provided by the mental health professionals in the MCPs' networks (outside of the primary care physician's scope of practice) and include: Individual and group mental health evaluation and treatment (psychotherapy); Psychological testing, when clinically indicated to evaluate a mental health condition; Outpatient services for the purposes of monitoring drug therapy; Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and Psychiatric consultation (p. 62-63). MCPs are required to enter into a Memoranda of Understanding (MOUs) with the county mental health plans (MHPs) that provide SMHS to ensure care coordination as beneficiaries are referred between the two systems (described in APL 13-018), which are all complete (p. 63, California 2017 Medicaid Managed Care Quality Strategy Annual Assessment).

[6] Overall DHCS Quality Strategy Priorities… Engage persons and families in their health (p. 15). Optimize beneficiary engagement…This is an ongoing topic during all the Quality Improvement collaborative discussions. DHCS continues to support MCPs learning from each other about barriers that have the greatest effect and thus the highest opportunity for impact. The National Governor's Association grant, which DHCS was awarded in 2015 is an example of this. DHCS, CDPH, the Sacramento County Public Health Department and three MCPs in Sacramento County worked together to improve childhood immunization rates through a joint PDSA project. The MCPs targeted high-volume provider groups that they all contract with and shared beneficiary engagement strategies, such as countering cultural barriers to parents obtaining immunizations for their children. The grant ended in 2016; however, the three MCPs involved in the project have indicated a desire to continue working with one another on childhood immunization rates in Sacramento because they found the collaboration useful. One of the MCPs demonstrated increases in their CIS-3 rates that they attribute directly to the collaborative grant work. DHCS hopes that the success of this MCP collaborative leads to other such opportunities amongst the MCPs. … DHCS continues to monitor MCP beneficiary education, outreach, and incentives programs. DHCS has determined that the majority of MCPs use beneficiary or member incentive programs to encourage healthy behaviors, such as screening for cervical cancer, establishing healthy eating habits or exercising, and obtaining prenatal and/or postpartum care. Providing gift cards to members with diabetes who complete their HbA1c testing is an example of how member incentives are used. Some member incentive programs are ongoing, allowing the MCP to track the impact of the program over time. In the first seven months of 2017, five MCPs started new diabetes incentive programs, three started new immunization incentive programs, and seven started new prenatal and/or postpartum care incentive programs. MCPs have member incentive programs on a myriad of topics, including chronic disease management, well-child care, immunizations, and cervical cancer screening. Including new and ongoing member incentive programs, currently eight MCPs have programs for cervical cancer screening, well-child care, immunizations, postpartum care, and completing the HbA1c test. Seven MCPs have a member incentive program for diabetes disease management, and six MCPs have programs for prenatal care and hypertension. DHCS continues to monitor and approve member incentive programs developed by the MCPs. DCHS updated the beneficiary or member incentive program process for MCPs, and now reviews and monitors MCP use of incentives for focus groups and beneficiary surveys (p. 38-39, California 2017 Medicaid Managed Care Quality Strategy Annual Assessment).

[7] Section 3: Improvement and Interventions. A. DHCS Initiatives and Interventions to Improve Quality of Care. 1. DHCS Initiatives to Improve the Quality of Care. These initiatives respond to important gaps in care that have large consequences on individual and population health, as well as on the Medi-Cal budget. These areas are a subset of all health needs of MCP beneficiaries. Focusing on these five areas for the next three years should strengthen organizational structure and capacity to enable DHCS and its contracted MCPs to make improvements in the overall quality of health care services. Table 3-1. Estimated Impact of MCP Performance: Beneficiaries Documented to have Received Appropriate Care ("Served") vs. Not "Served," MY 2016 (RY 2017).

Performance Measures. Controlling High Blood Pressure; Diabetes Care: HbA1c testing; Diabetes Care: Blood Glucose; Immunization Coverage; Postpartum Care; Tobacco Cessation: Advised to quit; Tobacco Cessation: Discussed medication to quit (p. 34-35). 2. DHCS Interventions from State Fiscal Year (SFY) 2015-2016 and SFY 2016-2015 g) Measure, report and use MCP performance DHCS continues to include six EAS measures in the auto-assignment algorithm (Controlling Blood Pressure, Cervical Cancer Screening, Childhood Immunization Status, Timeliness of Prenatal Care, W-34, and Comprehensive Diabetes Care: HbA1c Testing), where MCPs with higher performance than other(s) operating in the same county are rewarded by receiving new beneficiaries who do not actively choose to enroll in a particular MCP. This helps to ensure that MCPs with higher quality performance on key areas are rewarded (p. 36-44, California 2017 Medicaid Managed Care Quality Strategy Annual Assessment).

[8] DHCS has identified 12 threshold languages, including English, based on the Medi-Cal population with mandatory aid codes in each county. DHCS uses the threshold language data to determine which languages to translate enrollment and informing materials into for each county. Interpreters must be available to interpret conversations between Medi-Cal enrollees/beneficiaries and enrollment customer service representatives. In addition, MCPs must use the threshold language criteria to determine the languages into which informing materials must be translated MCPs must also arrange for appropriate cultural and linguistic support to limited English proficient beneficiaries, including interpreter services in provider offices (p. 31-32). The MCPs targeted high-volume provider groups that they all contract with and shared beneficiary engagement strategies, such as countering cultural barriers to parents obtaining immunizations for their children. The grant ended in 2016; however, the three MCPs involved in the project have indicated a desire to continue working with one another on childhood immunization rates in Sacramento because they found the collaboration useful (p. 38). DHCS continues to explore avenues to increase opportunities to share evidence-based strategies and best practices among MCPs. In addition to Quality Improvement collaborative discussions, Medical Director Meetings, and Health Education and Cultural and Linguistic Workgroup meetings, DHCS instituted a new avenue to share evidence-based strategies and best practices in 2015 and 2016 (p. 39, California 2017 Medicaid Managed Care Quality Strategy Annual Assessment).

[9] The Department identified improving health care access and outcomes as a program goal. One strategy the State employs to achieve this goal is through the assurance of adequate capacity and services. (p.20); The Department has a goal to reduce disparities in access to and utilization of primary and specialty health care, preventive services, and reducing disparities in care for diverse populations through: Improving access to coordinated services so that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing (p. 22). A primary focus of the Department is to ensure members have adequate access to care and receive services from appropriate providers. The Department fosters adequate access to care through several programs and projects. One such program is non-emergent medical transportation; the Department provides this mandatory state plan benefit that is offered to eligible members in order to receive transportation to covered Health First Colorado services when the members have no other means of transportation. The Department and Public Utilities Commission also implemented a new Public Utilities Commission permit to make it easier for Non-emergent Medical Transportation providers to obtain a permit to provide services while also not changing requirements for existing Non-emergent Medical Transportation providers (p. 22). Other access to care elements include the Health First Colorado Nurse Advice Line, which provides free 24-hour access to medical information and advice. The nurse advice line triages members and advises them on how urgently their health concerns should be addressed and which level of care is most appropriate for them to access (p. 22). The Department initiated strategies and improvements to expand provider networks serving the Medicaid population such as the Primary Care Medical Provider (PCMP) Outreach and Enrollment Program. The goal of the program is to increase the number of providers available as PCMPs. Rural PCMPs are targeted through outreach at Rural Health Center Events. The Department will be supporting SIM's goal of recruiting 400 primary care practices and helping them transition to care delivery models that integrate physical and behavioral health care (p.24, Colorado 2018 Medicaid Managed Care Quality Strategy).

[10] Through their expanded scope of responsibility, the RAEs will promote the population's health and functioning, coordinate care across disparate providers, interface with long-term services and supports providers, and collaborate with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex member needs that span multiple agencies and jurisdictions (p. 3, Colorado 2018 Medicaid Managed Care Quality Strategy).

[11] The Department identified integrating primary care and behavioral health services as one of its managed care program goals (p. 6). In order to achieve this goal, the Department will launch the second phase of the State's latest managed care model called the Accountable Care Collaborative (ACC), which is a PCCM Entity Program. Phase II is intended to move the program toward a more coordinated and integrated health system (p. 32). Practices that participate in SIM, including those that also participate in Comprehensive Primary Care Plus, receive the following supports: Access to apply to small grants to fund behavioral health integration (p. 13). On July 1, 2018, one organization, a Regional Accountable Entity (RAE), in each of the seven ACC regions will be responsible for promoting physical health and behavioral health, including administering the Department's capitated behavioral health benefit. Each RAE will perform as a single administrative organization for behavioral health and physical health (p. 2-3). To achieve these goals, the Department will: join physical and behavioral health under one accountable entity; strengthen coordination of services by advancing team-based care and health neighborhoods (p. 3). The primary responsibility of the RAE will be creating a cohesive network of primary care physical health providers and behavioral health providers who work together seamlessly and effectively to provide coordinated health care services to members (p. 4). Goals of HTP: Increase collaboration between hospitals and other providers, particularly ACC participants, in data sharing, analytics and evidenced-based care coordination and transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health and disparities reduction efforts (p. 33). The Department is developing a series of report cards to compare cost and quality of care among different types of service providers. This new initiative will help identify areas for improvement and provide valuable feedback for providers. (p.15) In the future, the Department plans to create additional report cars, such as a Primary Care Provider report card and a Long-Term Services and Supports report card (p.16, Colorado 2018 Medicaid Managed Care Quality Strategy).

[12] The Department will… promote member choice and engagement (p. 3). The Department has implemented a person-centered approach to its operations with the goal of ensuring that all employees, providers, clients and their families experience person centered policies, practices, and partnerships that respect and value individual preferences, strengths, and contributions. This includes development of in-person and virtual Member Experience Advisory Councils to work on person-and family-centered projects (p. 5). National Priorities …Ensuring that each person and family are engaged as partners in their care (p. 6). The Department has a goal to reduce disparities in access to and utilization of primary and specialty health care, preventive services, and reducing disparities in care for diverse populations through… Requiring MCOs/PIHPs/PCCMes to focus on promoting effective member engagement strategies (p. 22, Colorado 2018 Medicaid Managed Care Quality Strategy).

[13] Monitoring and Compliance 438.204(b)(3). QHI uses many sources and types of data to look at the structure, process and outcome of care and services provided to Health First Colorado clients. These areas are outlined below. Accountable Care Collaborative Performance Measures. Below are incentives and other measures being monitored by the Department. Key Performance Indicators 2017-2018: ER Visits – Per thousand, per year (PKPY), postpartum care, well-child checks (3-9). ACC Key Performance Indicators 2018-2019: Behavioral health engagement, dental visits, well visits (all ages), prenatal engagement, emergency department visits (PKPY), Health Neighborhoods (to be defined), Potentially avoidable costs (to be defined). Other performance measures: Well-Child Checks (0-21), 30-day Readmits PKPY, High Cost Imaging PKPY, Chlamydia Screening in Women, 30-day Post Discharge Follow Up, Depression Screening, Adult Clients with Diabetes and Annual HBA1c (p. 13). Dashboards. The Department continues to create a reporting strategy for all its health-plan specific measures to develop external-facing interactive dashboards. The purpose of these dashboards is to create accountability, transparency and drive performance improvement within our Medicaid program. Data presented will come from validated measures from various sources, including Healthcare Effectiveness Data and Information Set (HEDIS) and CAHPS. Three-year trends will be provided as available, as well as Department goals, to allow for health plan assessment and comparison. HEDIS® Performance Measures. The Department selects HEDIS measures for reporting each year. Reporting organizations include all contracted MCOs, PIHPs, and Health First's fee-for-service (FFS) program. Measures are selected annually using input from the MCOs, PIHPs and Department staff. Below are the 2018 HEDIS measures proposed to be reported by the Department: Adult Body Mass Index Assessment, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Childhood Immunization Status Combos 2-10, Immunizations for Adolescents, Breast Cancer Screening, Cervical Cancer Screening, Non-Recommended Cervical Cancer Screening in

Adolescent Females, Chlamydia Screening in Women, Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with Upper Respiratory Infection, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Use of Spirometry Testing in Assessment and Diagnosis of COPD, Pharmacotherapy Management of COPD Exacerbation, Medication Management for People with Asthma, Asthma Medication Ratio, Statin Therapy for Patients with Cardiovascular Conditions, Persistence of Beta-Blocker Treatment After Heart Attack, Statin Therapy for Patients with Diabetes, Comprehensive Diabetes Care, Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis, Use of Imaging Studies for Low Back Pain, Anti-depressant Medication Management, Use of Multiple Concurrent Antipsychotics in Children and Adolescents, Adults' Access to Preventive/Ambulatory Health Services, Children and Adolescents' Access to Primary Care Practitioners, Annual Dental Visit, Prenatal and Postpartum Care, Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life Adolescent Well-Care, Frequency of Selected Procedures, Ambulatory Care -Outpatient and/or ED, Inpatient Utilization –General Hospital/ Acute Care, Antibiotic Utilization, Annual Monitoring for Patients on Persistent Medications. The Department is developing a series of report cards to compare cost and quality of care among different types of service providers, such Federally Qualified Health Centers, hospitals, and primary care providers. This new initiative will help identify areas for improvement and provide valuable feedback for providers. The report cards will be shared with providers, their representative agencies and eventually made public. The report cards will be updated quarterly.; In the future, the Department plans to create additional report cards, such as a Primary Care Provider report card and a Long-Term Services and Supports report card (p. 14-16). Performance Improvement Projects (PIPs)are undertaken by each MCO, PCCM Entity and PIHP. Each plan previously selected at least one PIP and chose study topics based on data that identifies an opportunity for improvement. For the upcoming state fiscal year, the plans will choose two PIP topics (with the exception of the CHP+ plans, which will choose one topic). They will choose a behavioral health and physical health topic (p. 16, Colorado 2018 Medicaid Managed Care Quality Strategy).

[14] Colorado places the onus on MCOs/PIHPs/PCCMes to assess the race, ethnicity, and primary languages spoken translation and interpretation needs for their enrollees and to address those needs accordingly (p. 9). The Department requires contractors to establish and maintain written policies and procedures regarding the rights and responsibilities of members which is accessible through the Health First Colorado Member Handbook. The information in the handbook is provided at a 6th grade reading level, is translated into other non-English languages prevalent in the service area and may be in alternative formats. Oral interpretation services are also made available to members (p. 25, Colorado 2018 Medicaid Managed Care Quality Strategy).

[15] The Department is engaging in Primary Care Payment Reform in order to shift providers from volume to value and make differential fee-for-service payments based on provider's performance. The payment model aims to give providers greater flexibility in care provided, reward performance, and maintain transparency and accountability in payments made (p.33). In developing the proposed framework, the Department strives to create a single Health First Colorado primary care payment model that aligns with other state and national initiatives such as the Comprehensive Primary Care Initiative, Comprehensive Primary Care Plus, Enhanced Primary Care Medical Provider incentive program, Medicare Access and CHIP Reauthorization Act of 2015, and SIM, as well as with National Committee for Quality Assurance standards for Patient-Centered Medical Homes (p. 34, Colorado 2018 Medicaid Managed Care Quality Strategy).

[16] Goals, Values and Guiding Principles. Goat 1: To improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive, and behavioral healthcare, and to remain in a safe and least-restrictive environment. (P. 5); Table 3: Summarizes State-defined access standards. Appointment Standard (General): Emergency PCP: Available same day; Urgent care PCP: Available within two calendar days; Routine care: Available within three weeks of member request (p. 37, Delaware 2018 Medicaid Managed Care Quality Strategy).

[17] MCO Vender Reporting: 100% of case management files audited demonstrate coordination of care with PCP (p. 21). DSAMH Promise Vender Reporting: 100% of PROMISE care management files audited demonstrate the care manager has developed a written service plan that reflects services authorized appropriate to the level of care (p. 22). Currently, the State requires five PIPs, two mandated clinical topics; 1) Oral Health of the LTSS population which is prescriptive in nature and 2) behavioral and physical health integration (p. 33). Goal 2: Improve quality of care and services provided to DSHP, DSHP Plus and CHIP members as one its managed care program goals. MCO vendor strategy tied to achieving this program goal include reporting on vaccinations, comprehensive diabetic care, case management file audit, including those that demonstrate coordination of care with PCP (p. 25, Delaware 2018 Medicaid Managed Care Quality Strategy).

[18] Members are supported in taking responsibility for their own health and health care through use of preventive care and education (p.6). The PI Committee tracks and trends the rates over time and determines if there are ways to …keep beneficiaries engaged in PROMISE [a program for people with BH and functional needs] (p. 18). A person-centered focus is a fundamental component of the PROMISE program. Recovery planning is developed in a person-centered manner with the active participation of the beneficiary, family, and providers and should be based on the beneficiary's condition, personal goals, and the standards of practice for the provision of the specific rehabilitative services (p.19, Delaware 2018 Medicaid Managed Care Quality Strategy).

[19] Delaware performance improvement projects. The MCOs will conduct PIPs that shall be designed to achieve, through ongoing rapid cycle measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. Currently, the State requires five PIPs, two mandated clinical topics; … 2) behavioral and physical health integration (p.33). Goal 1: Improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive care, behavioral health and to remain in a safe and least-restrictive environment as one of its managed care program goals. (p.5) Strategies used to meet this goal include MCO vendor reporting of key measures including adult access to primary and preventative care services: HEDIS specifications, audit of case management files, quarterly reporting on Performance Improvement Projects (PIPs) and annual reporting on adult and child core measurements (p.22, Delaware 2018 Medicaid Managed Care Quality Strategy).

[20] Cultural sensitivity to variation in the health care needs of a diverse population is an essential element in providing quality services and decreasing disparities (p. 6). To facilitate care delivery appropriate to client needs, the enrollment file also includes race, ethnicity, primary language spoken and selective health information, including disability status. The MCO will use information on race/ethnicity, language, and disability status to provide interpretive services, develop educational materials for employee training and facilitate member needs in the context of their culture, language, and ability requirements (p. 28, Delaware 2018 Medicaid Managed Care Quality Strategy).

[21] The MMA program is designed to ensure consumer protections and improve quality of care, ease of transition between health plans, and improved access to care for recipients in many ways, including these requirements within the health plan contracts: (a) Continuation of currently authorized services for up to 60 days until the new MMA plan's primary care provider and/or behavioral health provider has an opportunity to review the enrollee's treatment plan (p. 6). The entities are required to assure that primary care physician services and referrals to specialty physicians are available on a timely basis, to comply with the following standards: urgent care - within one day; routine sick patient care - within one week; and well care - within one month. The plans are required to have telephone call policies and procedures that shall include requirements for call response times, maximum hold times, and maximum abandonment rates. The primary care physicians and hospital services provided by the plans are available within 30 minutes typical travel time, and specialty physicians and ancillary services must be within 60 minutes typical travel time from the member's residence. For rural areas, if the plan is unable to contract with specialty or ancillary providers who are within the typical travel time requirements, the state may waive, in writing, these requirements (p. 29, Florida 2017 Draft Medicaid Managed Care Quality Strategy).

[22] Another facet in the care continuum is a contractual requirement for health plans to coordinate activities on the local level with the Healthy Start Coalitions in each county. This assists in addressing the psychosocial determinants of health at the local level, and addresses the disparities in care and birth outcomes throughout this diverse state (p. 15, Florida 2017 Draft Mediaid Managed Care Quality Strategy).

[23] The Patient-Centered Medical Home (PCMH) is a model of care that emphasizes care coordination and communication to transform traditional primary care into patient-centered care. PCMHs inspire quality in care, cultivate more engaging patient relationships, and capture savings through expanded access and delivery options that align patient preferences with payer and provider capabilities (p. 11). PCMH service delivery focuses on care coordination, access to care in the most cost-effective

setting, and an effective partnership between the primary care clinician, the interdisciplinary care team, and the patient and family. Patients benefit from this model of care because they have increased access to their primary care clinician and his/her interdisciplinary team; their care is tracked and coordinated; and PCMH models promote education and self-management by the patient and family (p. 12). The plan's written policies and procedures shall address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs, and effective action to promote quality of care (p. 47). Each plan and the plan's quality improvement program is required to demonstrate in each plan's care management how specific interventions better manage care and impact healthier patient outcomes to achieve the goal of providing comprehensive, high quality, accessible, cost effective, and efficient health care to Medicaid enrollees (p. 71). Goal: Reduce unnecessary ED visits, unplanned pregnancies, C-sections, hospital readmissions, inappropriate use of medications, etc. through prevention, planning, service accessibility. Current Initiatives Supporting Goals: Performance Improvement Projects: Well Child Visits in First 15 Months; Goal: Improve health literacy to engage recipients, families, consumers in healthcare planning and service delivery. Current Initiatives Supporting Goals: Patient Centered Medical Homes, Early Intervention Services (EIS). Goal: Promote clear communication among providers, plans, patients, families; promote care that is accessible, coordinated, co-located, optimal. Current Initiatives Supporting Goals: Clinical Quality Monitoring, Physical and Behavioral Health Integration, Care Coordination for Medically Complex Children (p. 4, Florida 2017 Draft Medicaid Managed Care Quality Strategy).

[24] Requirements within the health plan contracts… Healthy Behaviors programs to encourage and reward members for engaging in actions to improve their personal health, for example, a medically-approved smoking cessation program, a medically-directed weight loss program (p. 6). Prevention and Wellness--Consumer Engagement. PCMH service delivery focuses on … an effective partnership between the primary care clinician, the interdisciplinary care team, and the patient and family (p. 12). PCMH models promote education and self-management by the patient and family (p.12). Healthy Behaviors Programs—Consumer Engagement. Currently, ten of 16 MMA health plans offer additional Agency-approved enrollee Heathy Behaviors Programs related to pregnancy. These Healthy Behaviors Obstetric, Prenatal or Maternal Health programs reference evidence-based practices to support the effectiveness of consumer engagement through financial rewards to motivate the enrollee to take positive action. Specific plan interventions, goals, and/or milestones must be achieved before the enrollee receives predefined incentives and/or rewards (p. 16). The success of these programs or efforts is contingent upon consumer engagement to promote awareness of and access to contraceptives of choice…Several health plans host ongoing, in-person consumer forums around the state to solicit their members' comments and suggestions, and use this feedback to improve service toward the goal of improving health outcomes (p. 19). Findings from this report [on oral health] were also consistent with what was learned from other sources: an increase in consumer engagement, health literacy, and education is needed…Guided by this information from recipients, and with technical support from the CMS learning collaborative staff, Medicaid Quality staff developed an additional SOHAP intervention targeted at increasing the level of engagement of families and children in accessing oral health care…Various Florida stakeholders were consulted, along with other states' Medicaid staff who participated in the Children's Oral Health Initiative with CMS, in order to obtain technical assistance and learn from other states' best practices for consumer engagement (p.23). Oral Health Consumer Engagement... The initial campaign will last six months, after which the data and feedback will be assessed and the campaign will be tweaked or redesigned if necessary. The next phase will include messaging in Spanish and Creole. Assessment will be made to measure any increase in utilization of services; awareness of Medicaid dental benefits; knowledge of the importance of preventive dental health; and knowledge of how to access services (p. 25, Florida 2017 Draft Medicaid Managed Care Quality Strategy).

[25] F. Standards for Quality Measurement and Improvement and Contract Provisions. 2. Quality Assessment & Performance Improvement Program. (e) At least four state-approved Performance Improvement Projects (PIPs) must be performed by each Managed Medical Assistance (MMA) plan and at least two PIPs must be performed by each Long-term care (LTC) plan. Each study/project conducted by a plan must include a statistically significant sample of Medicaid lives. For MMA plans, one project must focus on each of the following topics: Improving prenatal and well child visits in the first 15 months; ... Population health issues within a specific geographic area (p.73). (f) The state requires the plans to collect data on patient outcome performance measures, as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) or otherwise defined by the state and to report the results of the measures to the state annually (p.75, Florida 2017 Draft Medicaid Managed Care Quality Strategy).

[26] Florida Medicaid also strives to provide high quality care to all enrollees, regardless of their race or ethnicity, sex, sexual identity, age, disability, socioeconomic state, and geographic location. The factors, known as health disparities, are considered in the development and implementation of all quality improvement and initiatives (p. 2). The plans are required to assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The plans are required to provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the state, the population speaking a particular foreign (non-English) language in a county is greater than five percent (p. 34-35, Florida 2017 Draft Medicaid Managed Care Quality Strategy).

[27] Part III. 2017 Update of Initiatives Supporting Goals. B) Moving Toward Value-Based Purchasing: Florida Medicaid Medical Assistance Physician Incentive Program (MPIP) 2) Development of the MMA Physician Incentive Program a) The Agency for Health Care Administration (the Agency) has taken this opportunity to implement a program providing quality-based incentive payments for physicians, to promote innovative systems of delivery of care that reward value over volume of care. Focusing first on pediatricians and OB/GYNs, the Agency solicited detailed input from each Medicaid health plan regarding the design of an incentive arrangement for qualifying physicians in the plans' networks. Each health plan was then given the option to adopt either the MPIP model defined by the Agency, or to establish its own unique program with Agency approval. Other physician types will be considered for inclusion in the MPIP program in the future (p.11, Florida 2017 Draft Medicaid Managed Care Quality Strategy).

[28] Goal 1: Improved Health for Medicaid and PeachCare for Kids (CHIP) Members. Goal 1, Objective 1: Improve access to high quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data. Goal 1, Objective 1 Strategy: Increase and monitor access to health services for members; Goal 1, Objective 1 Strategy Interventions: 1) Enroll local education agencies (LEAs) as telemedicine originating site providers to improve access to telemedicine services; (4) encourage co-location of physical health and behavioral health providers (p.9); Goal 2: Smarter Utilization of each Medicaid dollar. Goal 2, Objective 1: Improve member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates for the adult and the child populations compared with the CY 2014 rates as reported in June of 2020 based on CY 2019 data. Goal 2, Objective 1, Strategy 1: Reduce ER visits for ambulatory sensitive conditions. Goal 2, Objective 1, Strategy 1 Interventions: 2) Educate FFS providers and members about the availability of preventive health services and primary care access for Medicaid adult and child members; Goal 2, Objective 1, Strategy 2: Increase access to urgent care services. Goal 2, Objective 1, Strategy 2 Interventions: 2) CMOs to encourage primary care providers to expand office hours to accommodate after-hours urgent care (p.13-14). Section III State Standards. Access Standards. Provider Type. PCPs: Urban – Two (2) within eight (8) miles. Rural – Two (2) within fifteen (15) miles. Pediatricians: Urban – Two (2) within eight (8) miles; Rural – Two (2) within fifteen (15) miles. General Dental Providers: Urban – One (1) within thirty (30) minutes or thirty (30) miles; Rural – One (1) within forty-five (45) minutes or forty-five (45) miles. (p. 30); Timely Access to Care and Services. Provider Type. PCPs (routine visits): Waiting Time – Not to exceed fourteen (14) calendar days; PCP (adult sick visit): Waiting Time – Not to exceed twenty-four (24) clock hours; PCP (pediatric sick visit): Waiting Time – Not to exceed twenty-four (24) clock hours; Vision Providers: Waiting Time – not to exceed thirty (30) calendar days; Dental Providers: Waiting Time – Not to exceed twenty-one (21) calendar days (p. 33). The CMOs must also ensure in office wait times are within do not exceed state established timeframes for enrolled members (see below): Scheduled Appointments: Wait times shall not exceed 60 minutes. After 30 minutes, the patient must be given an update on the wait time with an option of waiting or rescheduling the appointment. Work-in or Walk-In Appointments: Wait times shall not exceed 90 minutes. After 45 minutes, the patient must be given an update on the wait time with an option of waiting or rescheduling the appointment (p. 34). Residents across the state of Georgia have benefitted from the growth of telemedicine originating sites and DCH is working with the CMOs to improve the number of these sites to expand access to care, including specialty care, statewide (p. 51). In order to identify health conditions

early in their course, DCH recently revised its office visit policy to allow adult Medicaid members access to preventive health visits and services. Performance metrics to track the increased utilization of preventive services are monitored to demonstrate the effects of these primary prevention services in lowering the rate of growth in chronic diseases (p. 51). DCH received approval from CMS to allow access to preventive health services for Medicaid eligible adults aged 21 and older receiving care at federally qualified health centers and rural health centers. This approval led to a policy change allowing all Medicaid eligible adults in Georgia, aged 21 and older, to have access to an annual preventive health visit. The CMS Living Well marketing campaign materials will assist DCH and the CMOs with educating Medicaid members about this new service availability (p. 53). DCH initiated work to expand telemedicine originating sites to include local school districts (LEAs), thus improving members' access to providers especially in Georgia's rural counties (p. 53, Georgia 2016 Medicaid Managed Care Quality Strategy).

[29] Goal 1, Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data; Goal 1, Objective 2 Strategy: Increase preventative health and follow up care service utilization; Goal 1, Objective 2 Strategy Interventions: (1) Implement preventive health visits and screening services for members aged 21 years and older, (2) Monitor the Georgia Families (GF) and the Georgia Families 360 (GF360) Programs' quarterly 416 reports to ensure the EPSDT screening ratios achieve the 80% target rate, (4) Ensure the GF and the GF 360 programs achieve child and adolescent immunization rates at or above the HEDIS 90th percentile; 5) Implement provider payment for the smoking cessation counseling codes to promote utilization of this service, (7) Collaborate with the GF and the GF 360 programs to increase lead screening rates (p. 14, Georgia 2016 Medicaid Managed Care Quality Strategy).

[30] Section V: Delivery System Reforms. DCH promotes the establishment of patient-centered medical homes (PCMHs) as an evidence-based approach to managing patients with the potential for poor health outcomes and under the new CMO contracts, one of the value-based purchasing metrics relates to increasing the number of PCMHs. The new contracts also focus on the establishment of health and dental homes for the CMOs' assigned members and encourage the establishment of integrated behavioral and physical health homes (p .51, Georgia 2016 Managed Care Quality Strategy). Goal 1, Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids members so that health performance metrics relative to chronic conditions will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data. Goal 1, Objective 3 Strategy 1: Improve care coordination programs. Goal 1, Objective 3 Strategy 1 Interventions: (6) Encourage the establishment of patient-centered medical homes, behavioral health homes, and dental homes. Goal 1, Objective 3, Strategy 2: Improve evidence-based practices (p. 9-10). Goal 2: Smarter Utilization of each Medicaid dollar. Goal 2, Objective 1: Improve member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates for the adult and the child populations compared with the CY 2014 rates as reported in June of 2020 based on CY 2019 data. Goal 2, Objective 1, Strategy 1: Reduce ER visits for ambulatory sensitive conditions. Goal 2, Objective 1, Strategy 1 Interventions: 1) Ensure the GF and GF 360° CMOs assign each member to a medical home, 2) Educate FFS providers and members about the availability of preventive health services and primary care access for Medicaid adult and child members, 5) Collaborate with the GF and GF 360° CMOs to ensure incentives are in place to encourage the establishment of patient centered medical homes (p.14) Goal 2, Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all cause readmission rate for all Medicaid populations to 9% by the end of CY 2019 as reported in June of 2020. Goal 2, Objective 2, Strategy 1: Improve the transition of care process. Goal 2, Objective 2, Strategy 1 Interventions: 5) DCH to collaborate with the primary care providers delivering preventive health services to the fee for service population regarding appropriate discharge planning. Goal 2, Objective 2, Strategy 2: Ensure effective concurrent review and discharge-planning processes are in place for CMO and FFS members. Goal 2, Objective 2, Strategy 2 Interventions: 2) DCH to collaborate with the primary care providers for the fee for service population to ensure discharge planning for FFS members includes follow up visits and medication reconciliation (p. 14, Georgia 2016 Medicaid Managed Care Quality Strategy).

[31] Two Disease Management programs submit reports: Asthma and Diabetes. The reports assess the effectiveness of the CMOs' interventions to assist members with self-management of their diseases. (p. 20). DCH and the CMOs have discussed the following as some of the barriers to improved health outcomes… Difficulty engaging and maintaining the engagement of members in care management and disease management activities (p. 52, Georgia 2016 Medicaid Managed Care Quality Strategy).

[32] Quality and Appropriateness of Care As a requirement for accreditation, each CMO annually submits Healthcare Effectiveness Data and Information Set (HEDIS) performance measure rates at the specified time to NCQA. Each CMO also submits a set of performance measure rates, as specified by DCH, to the External Quality Review Organization (EQRO) for validation as required by the Code of Federal Regulations (CFR). These rates, trended over time by DCH, identify areas of improvement in health status as well as areas in need of improvement. DCH uses performance measure rates and performance improvement projects (PIPs) to assess care delivered to members by a CMO in areas such as preventive screening and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DCH monitors aspects of a CMO's operational structures that promote the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems (p.16). Performance Improvement Projects Each CMO must conduct and report to DCH the results of its DCH specified Performance Improvement Projects (PIPs) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services. DCH expects these PIPs to have a favorable effect on health outcomes and member satisfaction. As of January 2016, each GF CMO will individually conduct four (4) PIPs and collaborate on one Bright Futures PIP with the GA Chapter of the American Academy of Pediatrics. Eight (8) improvement topic areas will be focused on throughout 2016. The GF 360 program will conduct three (3) PIPs. All CMOs will use the rapid cycle PIP methodology and follow the guidance provided in the PIP companion guide prepared by the DCH contracted EQRO. The broad topic areas for these PIPs include ... Bright Futures Periodicity Schedule, Avoidable ER Use, Appropriate Use of ADHD Medications, Diabetes Care, [and] Postpartum Care (p.29, Georgia 2016 Medicaid Managed Care Quality Strategy).

[33] According to the DCH contract, the state is to provide the CMOs with its methodology for identifying the prevalent non-English languages spoken by members. The CMOs are required to notify members of the availability of oral translation/interpretation services and to provide the services as needed. This information incorporated into the CMOs' written Cultural Competency Plans, describes how they will ensure services rendered to all members are provided in a culturally sensitive manner (p. 17). The GF and GF 360o CMOs are required to provide outreach, training, and guidance to providers and members to support equal access to quality and culturally competent care, including language access services for individuals with limited English proficiency, and auxiliary aids and services for individuals with disabilities. In accordance with the National Action Plan to Improve Health Literacy, the CMOs must offer educational materials on disease states prevalent in their population while offering providers strategies for improving the health literacy of their patient populations. Through monitoring and collection of health data by race, ethnicity, sex, primary language, socioeconomic factors, and disability status, DCH ensures the effectiveness of the CMOs efforts in this area (p. 34, Georgia 2016 Medicaid Managed Care Quality Strategy).

[34] Goal 1: Improve preventative care for women and children. Goal 1 Objectives: Childhood Immunizations – increase performance on the state aggregate HEDIS Childhood Immunization measure to meet/exceed the 2015 Medicaid 75th percentile;; Breast Cancer Screening – increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the 2015 Medicaid 75th percentile;; Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services: Increase participant ratio on the state aggregate Participant Ratio to meet/exceed 80 percent for children of all ages (p. 13). Goal 2: Improve healthcare for individuals who have chronic illnesses. Goal 2 Objectives: Comprehensive Diabetes Care Measures – increase performance on the state aggregate HEDIS Diabetes Care Measures for A1c testing to meet/exceed the 2015 HEDIS 75th percentile ... for A1c control (>9) to meet/exceed the 2015 HEDIS 50th percentile … for A1c control (<8) to meet/exceed below the 2015 HEDIS 50th percentile, "..." for blood pressure control (<140/90) to meet/exceed the 2015 HEDIS 75th percentile ... for eye exams to meet/exceed the 2015 HEDIS 75th percentile; Blood Pressure Control in the General Population – increase performance on the state aggregate HEDIS Blood Pressure Control (BP <140/90) measure to meet/exceed the 2015 HEDIS 75th percentile; Appropriate Medications in Asthma – increase performance on the state aggregate HEDIS Asthma measure to meet/exceed the 2015 HEDIS 75th percentile; Reduce the percent of asthma related Emergency Department visits for Medicaid beneficiaries ages 0 to 20: decrease the percentage of asthma related Emergency Department visits to less than or equal to 6% (p. 13-14). Goal 1,

Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data; Goal 1, Objective 2 Strategy: Increase preventative health and follow up care service utilization; Goal 1, Objective 2 Strategy Interventions: (1) Implement preventive health visits and screening services for members aged 21 years and older, (2) Monitor the Georgia Families (GF) and the Georgia Families 360 (GF360) Programs' quarterly 416 reports to ensure the EPSDT screening ratios achieve the 80% target rate, (4) Ensure the GF and the GF 360 programs achieve child and adolescent immunization rates at or above the HEDIS 90th percentile; 5) Implement provider payment for the smoking cessation counseling codes to promote utilization of this service, (7) Collaborate with the GF and the GF 360 programs to increase lead screening rates; Goal 4: Improve cost-efficiency of health plan services. Goal 4 Objectives: Follow-Up After Hospitalization for Mental Illness: increase performance on state aggregate HEDIS Follow-Up After Hospitalization for Mental Health Illness measure to meet/exceed the 2015 HEDIS 75th percentile. In addition, MQD recognizes that much of "health" is beyond the clinic walls related to the social determinants of health. MQD is also focused on working with the larger community in improving health by focusing on healthy communities and healthy families (p. 4, Hawaii 2016 Medicaid Managed Care Quality Strategy).

[35] Guiding Principles. The MQD's quality approach aspires to the following: Patient-Centered Medical Home – The MQD seeks to advance the patient-centered medial home. In a medical home, the patient's personal physician and his or her team take responsibility for managing, coordinating, and integrating preventive, acute, chronic, long term, and end of life care, across all elements and continuum of a complex health care system. Care is facilitated by information technology, health information exchange, and other means to assure the patients get necessary care in a manner that is effective, safe, prompt, and culturally/linguistically appropriate (p. 5). The goals for the QUEST Integration Program are: … Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (p. 6). In the upcoming year, additional goals focused on the Integration of Behavioral Health, and supporting Healthy Communities/Healthy Families will be developed (p. 15, Hawaii 2016 Medicaid Managed Care Quality Strategy).

[36] The current mandatory PIP topics for the QUEST Integration MCOs are Plan All Cause Readmission and Diabetes Self-Management (p. 27). The MQD continually strives to improve the health status of its program beneficiaries by promoting MCO population-based care, provider quality of care, and patient healthy behaviors and self-management (p. 7, Hawaii 2016 Medicaid Managed Care Quality Strategy).

[37] HEDIS Results: The MQD requests HEDIS data from the MCOs annually. These are tracked and trended. They are used for comparisons among MCOs, discussed collaboratively among MCOs to promote sharing of best practices, and may serve as a basis for public reporting and financial incentive programs. The EQRO validates all of the HEDIS measures annually and included in the EQRO Technical Report (p.22). Performance Improvement Projects A PIP is intended to improve the care, services, or member outcomes in a focus area of study. MQD selects certain PIP topics to be collaboratively performed by the MCOs. The current mandatory PIP topics for the QUEST Integration MCOs are Plan All Cause Readmission and Diabetes Self-Management (p.27, Hawaii 2016 Medicaid Managed Care Quality Strategy).

[38] MQD has adapted the Institute of Medicine's (IOM) framework of quality and strive for our beneficiaries to receive care that is… Equitable – without disparities based on gender, race, ethnicity, geography, and socioeconomic status (p. 4, Hawaii 2016 Medicaid Managed Care Quality Strategy).

[39] Goal 1: Improve Iowans' Health Status. Strategy: Promote better health and nutrition for DHS clients including preventative care. Key Outcomes and Indicators: Percentage of Medicaid members reported receiving a preventative visit in the past 12 months (p. 6, Iowa 2016 Medicaid Managed Care Quality Strategy).

[40] For the Families and Children Population and ACA Adult Enrollees, MCO's maximum PCP panel size shall be eighteen hundred (1,800) Enrollees. An additional maximum of nine hundred (900) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant and advanced practice nurse who is 100% FTE. For Seniors and Persons with Disabilities Enrollees, MCO's maximum PCP panel size shall be six hundred (600) enrollees. An additional maximum of three hundred (300) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant and advanced practice nurse who is 100% FTE. If MCO does not satisfy the PCP requirements set forth above, MCO may demonstrate compliance with these requirements by demonstrating that (i) MCO's full time equivalent PCP ratios exceed ninety percent (90%) of the requirements set forth above, and (ii) that covered services are being provided in the contracting area in a manner which is timely and otherwise satisfactory. MCO shall comply with Section 1932(b)(7) of the Social Security Act (p. 9, Appendix H). MCOs must adhere to travel time and distance standards: Primary Care: MCO shall ensure an Enrollee has access to at least two (2) primary care Providers within a thirty (30)–mile radius of or thirty (30)– minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) primary care Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. Dental access for children: MCO shall ensure an Enrollee has access to at least one (1) dentist, who serves Children, within a thirty (30)–mile radius of or thirty (30)– minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) dentist, who serves Children, within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence (p. 10, Appendix H). MCOs shall require that time-specific appointments for routine preventive care are available within five (5) weeks from the date of request for such care, and within two (2) weeks for infants under age six (6) months, from the date of request. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day of the request. Enrollees with problems or complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Network Providers shall offer hours of operation that are no less than the hours of operation offered to persons who are not Enrollees (p. 11, Appendix H). Primary care and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week, and they shall have a published after-hours telephone number; voicemail alone after hours is not acceptable (p. 12, Appendix H, Illinois 2016 Medicaid Managed Care Quality Strategy).

[41] Goal 4: Improve participation in preventative care and screenings, Goal 4 Objectives: HEDIS performance measures, provider and member incentive programs, care gap reporting, focused quality forums on preventive care that include community stakeholders, HFS, and health plans (p. 11). Health plans are required to collaborate with community-based organizations to address social determinants of health, assess beneficiary needs, formulate collaborative responses, and evaluate outcomes for community health improvement and eliminating health disparities (p. 19, Illinois 2016 Medicaid Managed Care Quality Strategy).

[42] Illinois' behavioral health transformation strategy, developed to support the 1115 Medicaid demonstration waiver, puts customers at the center, integrates behavioral and physical health, and transforms a fragmented and unsustainable system with new payment and delivery models, increased managed care, enhanced workforce capacity, and greater accountability across the system (p. 42). 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. 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 (p. 23). Building on a managed care system that carved behavioral health into the medical program, HFS aims to enhance true integration of behavioral and physical healthcare through an ambitious integrated behavioral and physical health home program (integrated health homes or IHHs) that promotes accountability, rewards team-based integrated care, and shifts toward a system that pays for value and outcomes (p. 44). Goal 1: Improve population health improvement. Goal 1 Objectives: Healthcare Effectiveness Data and Information Set (HEDIS) performance measures; Behavioral health and physical health integration; Implementation and

integrated health homes; Risk stratification – identify high-risk/high-cost beneficiaries; Care management/care coordination (CM/CC) programs; Care transition programs (p. 11). Goal 5: Promote integration of behavioral and physical healthcare, Goal 5 Objectives: Implementation of integrated health homes, behavioral health care transition programs, HEDIS measures (p. 12). The Department has directed the health plans' efforts on the focus populations and initiatives described herein: Focus Population – Behavioral Health (related to Goal 5); Initiative – HFS worked toward the development of a mental health assessment and service plan of care tool called the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IN-CANS) tool, which will be used by Medicaid providers. This tool will be designed to improve behavioral health outcomes by providing standardization, continuity, and consistency in identifying and treating beneficiaries with behavioral health needs. HFS plans to develop measures that will gauge the success of BH/medical integration to help direct adjustments and needed resources (p. 36-37). Focus population – All Populations (related to Goal 5); Initiative – HFS plans to begin implementing integrated health homes through a separate State plan amendment in October 2018. The integrated health home will focus on coordination of care spanning physical healthcare, behavioral health care, and social needs. HFS believes that care coordination system to be very individualized and dependent on each member's different needs. Health home members will be divided into tiers, with Tier A for members with physical and behavioral health needs, Tier B for high behavioral with low-to-moderate physical health needs, and Tier C for high physical with low-to-moderate behavioral health needs. Most Medicaid members are within Tier D, members with low physical and behavioral health needs. However, Tier A providers will have to accept members from all tiers in order to serve the entire family unit, allowing a family to be served by the same health home with the overall goal of truly integrated health homes (p. 38, Illinois 2016 Medicaid Managed Care Quality Strategy).

[43] EQR Recommendations – Quality Improvement Plan…Evaluate the effectiveness of diabetes disease management programs to determine effectiveness of educational materials for diabetes care…Implement a diabetes interactive voice response (IVR) call campaign to target members who are not compliant with their disease management…Implement targeted outreach campaigns for members who have not accessed preventive care services (p. 6-9, Appendix J, Illinois 2016 Medicaid Managed Care Quality Strategy).

[44] Quality Improvement Interventions. Focus Population – Healthy Adults. Initiatives – Based on recommendations from the most recent EQR technical report, HFS is considering the Adults' Access to Preventive/Ambulatory Health Services – Total measure for the P4P program, as the rates have been low and contribute to the wellbeing of beneficiaries across multiple domains of care.; Focus Population – Behavioral Health. Initiatives - HFS worked toward the development of mental health assessment and service plan of care tool called Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS) tool, which will be used by Medicaid providers. This tool will be designed to improve behavioral health outcomes by providing standardization, continuity, and consistency in identifying and treating beneficiaries with behavioral health needs (p.36).; HFS plans to develop measures that will gauge the success of BH/medical integration to help direct adjustments and needed resources (p. 37, Illinois 2016 Medicaid Managed Care Quality Strategy).

[45] Health plans are required to develop and implement a cultural competency plan, offer appropriate foreign language versions of all beneficiary materials, and develop member materials which can be easily understood at a sixth grade reading level…. The plan is submitted to HFS for approval. Plans are required to offer trainings to health plan staff and network providers. …Health plans are required to proactively attempt to hire staff who reflect the diversity of enrollee demographics. Plan staff are required to complete linguistic and cultural competence training upon hire and no less frequently than annually. Health plans are required to have a process to verify subcontractors' and provider network's compliance with the plans' Cultural Competency Plan…HFS uses the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) to evaluate the health plan cultural competency program plans (p. 19). MCO shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multi-lingual Providers. Provider contracts will require compliance with MCO's Cultural Competence Plan (p. 15, Illinois 2016 Medicaid Managed Care Quality Strategy).

[46] Goal 7: Transition to value-and outcome-based payment. Goal 7 Objectives: Pay-for-performance (P4P) program, Integrated health homes (aligning financial incentives to evidence-based practices and tiered bonus levels based on performance outcomes) (p. 12, Illinois 2016 Medicaid Managed Care Quality Strategy).

[47] OMPP has identified four global aims that equally support HHW, HIP and HCC goals and objectives. These are: 2) Prevention – Foster access to primary care and preventative care services with a family focus. a) promote primary care and preventive care (p. 5). Healthy Indiana Plan Program: Objective 1) HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence; Goal: 90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence. 2) HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of the member's residence (p. 8). The MCEs must provide access to PMPs within at least thirty (30) miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians (HHW only), gynecologists and endocrinologists (if primarily engaged in internal medicine). Due to the characteristics of needs for members who are aged, blind or disabled, in HCC any physician may be an individual's PMP (p. 21). Each health plan must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty four (24)-hours-a day, seven (7)-days-a-week. In addition, PMPs must have a mechanism in place to offer members direct contact with their PMP or the PMP's qualified clinical staff person, through a toll-free telephone number twenty four (24)-hours-a-day, seven (7)-days-a-week. Each PMP must be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. Each MCE must also assess the PMP's patient base who are not members of HHW, HIP and HCC to ensure that the PMP's HHW, HIP and HCC population is receiving services on an equal basis with the PMP's non-managed care population (p. 21-22). The health plans must ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The health plans must also ensure that members have telephone access to their PMP (or appropriate designee such as a covering physician) in English and Spanish twenty-four (24)-hours-a-day, seven (7)-days-a-week (p. 22, Indiana 2018 Medicaid Managed Care Quality Strategy).

[48] Hoosier Healthwise Program: Objectives: 1) Improvements in children and adolescent well-care (HEDIS); Goal: Achieve at or above the 90th percentile for improvements in children and adolescent well-child (HEDIS), 2) EPSDT; Goal: Achieve at or above 80% participation rate in the EPSDT program, 3) Improvement in behavioral health (HEDIS); Goal: Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS), 5) Medication Management for People with Asthma; Goal: Achieve at or above the 90th percentile for medication management for people with asthma, 6) Lead Screening in Children; Goal: Achieve at or above the 75th percentile for lead screening in children (p. 6). HIP Program: Objectives: 3) POWER Account Roll-Over; Goal: Achieve at or above 85% of the number of members who receive a preventative exam during the year, Objective and Goal 5) Same as objective and goal #3 of Hoosier Healthwise 6) Adult Preventative Care (HEDIS); Goal: Achieve at or above the 90th percentile for the percentage of members who had a preventative care visit, 8) Pregnant Women Smoking Cessation; Goal: Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline (p. 8). Hoosier Care Connect Program: Objectives: 1) Preventative Care (HEDIS); Goal: Achieve at or above the 75th percentile for members nineteen (19) years and older who had a preventative care visit (p. 11, Indiana 2018 Medicaid Managed Care Quality Strategy).

[49] OMPP has identified four global aims that equally support HHW, HIP and HCC goals and objectives. These are: 4) Coordination/Integration – encourage the organization of patient care activities to ensure appropriate care a) Integrate physical and behavioral health services (p .5). 8) Right Choices Program (RCP) – To provide quality health care through health care management OMPP requires each plan's RCP administrators to conduct utilization reviews, create a care coordination team and collaborate with each RCP member to ensure that the member receives appropriate, medically necessary care (p. 59). A detailed comprehensive health assessment is then completed and utilized to identify a member's individualized needs and ultimately

allow for stratification into the appropriate level of care coordination whether it be disease management, care management, or complex case management (p. 7). When the further assessment confirms the special health care need, the member must be placed in the appropriate level of care coordination, either care management or complex case management (p. 25, Indiana 2018 Medicaid Managed Care Quality Strategy).

[50] OMPP expects the contracted health plans to… Engage in provider and member outreach regarding preventive care, wellness and a holistic approach to better health (p. 4). OMPP requires that each health plan's utilization management program… Encourage health literacy and informed, responsible medical decision making. For example, the health plan should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting (p. 26). The MCEs should target education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards and to decrease inappropriate use of health care (p. 27). Each health plan must identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to ensure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, care management or complex case management services (p. 27). If the health plan incentivizes members to complete a health needs screen, a description of the member incentive is included in the Welcome Packet. (p. 28). For 2018 some MCEs will be utilizing kiosks located in retail businesses as well for members to be able to complete their health needs screen. Members who utilize these kiosks will receive a financial incentive upon completion of the screen which can then be utilized immediately in that specific retail business (p.29). Each MCE may use its own proprietary stratification methodology to determine which members should be referred to specific care coordination programs, ranging disease management involving member education and awareness efforts to care management or complex case management (p. 29). HIP provides incentives for members to be more health conscious by accessing preventive health care (p. 47). Appendix III: Healthy Indiana Plan & Enhanced Services Plan Historical Timeline…2018…Additional areas of focus in HIP to include expanded incentives program that offers outcome-based incentives to members specific to tobacco cessation, substance use disorder treatment chronic disease management and employment related incentives (p. 53, Indiana 2018 Medicaid Managed Care Quality Strategy).

[51] The HHW, HIP and HCC health plans submit quarterly clinical quality measures reports in various areas, such as the following: Preventative Services and Chronic Care; Prenatal and Postpartum Health Outcomes; Child and Adolescent Preventive Care; Behavioral Health; Utilization Management; and Ambulatory Care (p. 12). National Performance Measure The MCEs monitor, evaluate and take action to identify and address needed improvements in the quality of care delivered to members in the HHW, HIP and HCC programs. This includes necessary improvements by all providers in all types of settings. In compliance with State and federal regulations, the contracted health plans submit quality improvement data, including data that meets HEDIS standards for reporting and measuring outcomes, to OMPP. This includes data on the status and results of quality improvement projects. Additionally, the MCEs submit information requested by OMPP to complete annual quality reports (p.14, Indiana 2018 Medicaid Managed Care Quality Strategy).

[52] Data on race, ethnicity and primary language is sent to the MCEs via the Enrollment Roster. This information is to be utilized by the health plans to communicate effectively and appropriately with their population. The health plans must make all written information available in English and Spanish, and other prevalent languages, including American Sign Language, identified by OMPP, upon the member's request. In addition, each health plan must identify additional languages that are prevalent among its membership. The MCE must also inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative formats as Braille, large-font letters, audio, prevalent languages and verbal explanation of written materials. All materials must be approved by OMPP and be culturally appropriate. Verbal interpretation services must also be available and provided by the health plans upon request. The MCEs must also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of the populations that they serve (p. 20, Indiana 2018 Medicaid Managed Care Quality Strategy).

[53] Goal 4: Increase access to and availability of services. Objective 4.1: Improve adult access to primary and preventative care services. Objective 4.2: Improve children and adolescents' access to primary care practitioners (p. 15). Expansion of telemedicine factored into development of network adequacy standards (p. 21). The following standards are currently in place: Respond to referrals 24 hours per say seven says per week and provide access to evening and weekend appointments; Appointment times shall be in accordance with usual and customary standards not to exceed three weeks for regular appointments and 48 hours for urgent care; Waiting times shall not exceed 45 minutes (p. 22-23, Kansas 2018 Draft Medicaid Managed Care Quality Strategy).

[54] Managed Care Goals and Objectives: … coordinating services and supports for social determinants of health... coordinate care and social services, address social determinants of health... (p. 3). KanCare utilizes its Service Coordination requirements to assist individuals who need LTSS or who have special health care needs. This includes: ... Other individuals who may benefit from Service Coordination including those who are identified as having a need relating to social determinants of health and independence, such as housing, instability, food insecurity, and unemployment/under-employment (p. 10). Health Screenings, Health Risk Assessments (HRAs), and Needs Assessments must address the physical, behavioral, and functional needs of the member, as well as assist in identifying barriers to improved care outcomes including those related to Social Determinants of Health and Independence (p. 10). Section on Social Determinants of Health and Health Disparities (p. 11). The state identifies and quantifies... the characteristics and health care needs of the KanCare population including... services and provider types necessary to address physical and behavioral integration (p. 21). Evidence-based practice guidelines... should cover the following areas... social determinants of health and independence (i.e. smoking cessation, supported housing, etc.) (p. 23, Kansas 2018 Draft Medicaid Managed Care Quality Strategy).

[55] The goals of the KanCare program include: Provide integration and coordination of care across the whole spectrum of health to include [physical health], [behavioral health] (mental health and substance use disorders), and LTSS... (p. 3). Goal 5: Increase the use of evidence-based practices for members with BH (mental health and substance use disorder), and chronic physical health conditions. Objective 5.1: Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase. Objective 5.2: Increase follow-up care for children prescribed ADHD medication—continuation and maintenance phase. Objective 5.4: Increase follow-up after hospitalization for mental illness—7 days. Objective 5.5: Increase follow-up after hospitalization for mental illness—30 days. Objective 5.13: Increase medication management for people with asthma—medication compliance 75% (p.15-16, Kansas 2018 Draft Medicaid Managed Care Quality Strategy).

[56] All MCOs are expected to achieve the National HEDIS 75th percentile (25th percentile for inverse measures) for all reported HEDIS data. To support the State's continuous QI process, MCOs should take action to improve all HEDIS measures that have achieved the 75th percentile with the goal of obtaining the 90th percentile (10th percentile for inverse measures). HEDIS measures falling below the 75th percentile (25th percentile for inverse measures) and for all other non-HEDIS quantitative measures the State has devised the following PM improvement strategy aimed at reducing, by 10%, the gap between the PM baseline rate and 100%. For example, if the baseline rate was 55%, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5%. Each measure that shows improvement equal to or greater than the performance target is considered achieved (p. 16, Kansas 2018 Draft Medicaid Managed Care Quality Strategy).

[57] The MCOs are contractually required to evaluate and be responsive to members' health literacy needs, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. Within 90 days of starting operations, and annually thereafter, each MCO must submit a Cultural Competency Plan that, at a minimum, describes how the MCO will ensure care is delivered in a culturally competent manner, addresses how this will be achieved in rural areas of the State via telehealth strategies, the role of Social Determinants of Health and Independence in improving and sustaining positive health outcomes, strategies to assess and respond to the health literacy needs of members, goals of the program, and training and education of MCO staff, its provider network and members. The plan must also include a description of how the MCO will evaluate and conduct regular assessments of the provider network to ensure services are provided in a culturally competent manner to diverse populations, including taking action and improving the Cultural Competency Plan to address any variances. Contracted MCOs and their network providers and subcontractors that provide services to KanCare members participate in Kansas' efforts to deliver care in a culturally competent manner to all members. Additional information requirements specific to the Provider Directory include the capture of each provider's linguistic

capabilities, as well as whether the provider has completed cultural competence training, and whether the provider's offices, exam rooms, and equipment accommodate individuals with physical disabilities, in accordance with the Americans with Disabilities Act (p. 12). Goal 1: Improve the delivery of holistic, integrated, person centered, and culturally appropriate care to all members. Objective 1.1: Ensure each MCO develops, submits for review, and annually revises its cultural competency plan. Objective 1.2: Ensure each MCO submits an annual evaluation of their cultural competency plan to [Kansas Department of Health & Environment] must receive a 100 Met compliance score for all seven elements of the cultural competency plan outlined in the contract. Objective 1.3: Stratify data for PMs and utilization by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to holistic and integrated services. Objective 1.4: Increase the rate of providers who have completes an approved course in delivery of cultural competency (p. 13, Kansas 2018 Draft Medicaid Managed Care Quality Strategy).

[58] Goal 2: To improve accessibility to care and use of services for adults and children, with an emphasis on obtaining appropriate preventative and primary care. Objectives: Increase access to preventative/ambulatory health services for adults; increase access to primary care practitioners for children and adolescents (p. 16). The primary care network must have at least 1 full time equivalent PCP for every 2,500 patients. Physicians with physician extenders (NP/PA/certified nurse midwife or OB/GYNs only) may increase the physician ration by 1,000 per extender. The maximum number of extenders shall not exceed two extenders per physician (p. 42-43). When an enrollee changes primary care provider, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipts of request (p. 51, Louisiana 2011 Medicaid Managed Care Quality Strategy).

[59] Increase percentage of children who have at least six well visits within the first 15 months of life; increase percentage of children receiving well child visits in third, fourth, fifth and sixth years of life; Increase percentage of adolescents receiving well visits (p. 16). Goal 3: Improve effectiveness and quality of care. Objectives: Increase the percentage of pregnant women who are screened for tobacco usage and secondhand smoke exposure and are offered an appropriate and individualized intervention; Increase percentage of women receiving breast cancer screening; Increase percentage of women receiving cervical cancer screening; Increase immunization rates of children and adolescents; Increase weight assessment and counseling for nutrition and physical activity in children and adolescents; Increase appropriate testing for children with pharyngitis; Increase follow-up care rates for children prescribed attention deficit hyperactivity disorder (ADHD) medication; Increase HbA1C testing in all children and adolescents diagnosed with diabetes; Increase percentage of 5-56 year olds identified as having persistent asthma, who were appropriately prescribed asthma medication; Increase controlling high blood pressure rates for members with hypertension; Increase comprehensive diabetes screening rates for members with diabetes. (p. 17, Louisiana 2011 Medicaid Managed Care Quality Strategy).

[60] Goal 5: Increase coordination and continuity of services. Objectives: Increase the number of PCPs with NCQA Patient-Centered Medical Home Certification or Joint Commission Primary Care Medical Home Accreditation (p. 17, Louisiana 2011 Medicaid Managed Care Quality Strategy).

[61] The guiding principles and expected outcomes of the Medicaid Coordinated Care Network Program include the following…. Outreach and education to promote healthy behaviors… Increased personal responsibility and self management (p. 2-3). The following methods are intended to support the achievement of this mission… Emphasize prevention and self-management to improve quality of life… Supply providers and members with evidence-based information and resources to support optimal health management (p. 15). Annual Reports… Member Advisory Council plan (p. 38-39, Louisiana 2011 Medicaid Managed Care Quality Strategy).

[62] A. Louisiana Performance Measurement Set The State requires the plans to collect data on patient outcome performance measures, as defined by HEDIS, CHIPRA Initial Core Set, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, CAHPS or otherwise defined by the State, and reports the results of the measures to the State annually. Because the majority of the Louisiana Medicaid enrollment is children and adolescents, the preponderance of the performance measures are related to child or adolescent health. The State may add or remove reporting requirements with 30 days advance notice (p. 27). B. Louisiana's Performance Improvement Projects In accordance with 42 CFR 438.240, Louisiana requires that each plan perform a minimum of two State-approved PIPs, one clinical and one non-clinical. The DHH required PIP during the first contract year is listed in Section 1 of Table 3 below. The CCN shall choose the second PIP from Section 2. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs. Table 3: Louisiana Performance Improvement Project Section 1 – Ambulatory Care Measure – Emergency Department Visit Category; Section 2- Well Child Visits in the First 15 Months of Life; Childhood Immunization Status (p. 34-35, Louisiana 2011 Medicaid Managed Care Quality Strategy).

[63] The CCN is required to have available interpretive services for all languages other than English upon request. The CCN will encourage and foster cultural competency in its employees (p. 46). The EQRO monitors … cultural consideration (p. 79). The applicant's preferred language is also identified and forwarded to the MMIS. ...The CCN contractors are required to ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members of a CCN within the geographic service area (GSA). The State requires that the CCN and any contractors have translation services for those who speak any foreign language. The Enrollment Broker will provide multi-lingual interpreters and enrollment material in other alternate formats (large print, and/or Braille) when needed (p. 20, Louisiana 2011 Medicaid Managed Care Quality Strategy).

[64] Objective 1.2: Engage community-based organizations in partnerships to better communicate with our members and improve member access (p. 6, Massachusetts 2013 Medicaid Managed Care Quality Strategy).

[65] Goal 1: Deliver a seamless, streamlined, and accessible member experience. Goal 2: Promote integrated care systems that share accountability for better health, better care, and lower costs. Objectives: 2.1 Use alternative payment methodologies to promote care delivery innovations such as team based care, group visits, telehealth, virtual office visits, and community health workers, 2.2 Prioritize access to integrated models of care delivery for high cost members with complex care needs, 2.3 Promote and scale the patient-centered medical home across all MassHealth programs, 2.4: Operationalize primary-care behavioral health integration, 2.6 Leverage payment strategies to drive adoption and use of EHRs to enhance care coordination and quality improvement (p. 6). Coordination and Continuity of Care: includes ongoing source of primary care appropriate to the enrollee's needs, a formal designee primarily responsible for coordinating the health care delivered to the enrollee, linkages with staff in other agencies and/or community service organizations if the agency/organization is already involved in meeting the enrollee's needs, care management programs for any enrollee who needs assistance in coordinating physical and behavioral health care services and benefits, and team based care (p. 18-19). Goal 3: Shift the balance toward preventative, patient-centered, primary care, and community-based services and supports. Objectives 3.3 Hold providers accountable for reducing readmissions, ER visits and admissions for ambulatory sensitive conditions such as asthma and diabetes (p. 6). Primary Care Payment Reform (PCPR): The Primary Care Payment Reform demonstration seeks to expand access to primary care, improve patient experience, quality, and efficiency through care management and coordination, and to incorporate behavioral health care with primary care. This initiative is designed to support primary care delivery by giving providers flexibility and the resources needed to deliver care and services. A primary care payment system that combines a shared savings/risk arrangement with quality incentives is currently in development by MassHealth. The proposed model will be designed to support primary care through a patient-centered medical home in collaboration with integrated behavioral health services (p. 35, Massachusetts 2013 Medicaid Managed Care Quality Strategy).

[66] Objectives… 3.2 Promote active member engagement in the development of their care plan and self-management strategies for chronic diseases…3.5 Creatively engage and incentivize members to participate in wellness initiatives focused on smoking cessation and obesity (p. 6). The One Care Program adds services to the usual Medicare and Medicaid covered benefits to advance wellness, recovery, self-management of chronic conditions, independent living, and as alternatives to high-cost acute and long-term institutional services (p. 18). care management programs must be structured to accommodate the range of care needs exhibited by enrollees, to include, at a minimum, the following specific levels of care management: Case Management, Wellness and Disease Management, Complex Care Management and Intensive Clinical Management. These programs must include enrollee education for disease self-management (p. 19). Covered services in the One Care Program include …Added services

are designed to advance wellness, recovery, self-management of chronic conditions, independent living, and as alternatives to high-cost acute and long-term institutional services (p. 33-34). Health Needs Assessment (HNA) Plans ensure that each new enrollee receives an HNA form and make best efforts to have enrollees complete their HNA. All MCEs implement an outreach and follow-up process to encourage members to complete the HNA (p. 20). QI Goal Measures …Member Engagement in care Management (p. 25). QI Goal Quality Interventions … Design and implement one strategy to engage members in care management by level of care management need (p. 27, Massachusetts 2013 Medicaid Managed Care Quality Strategy).

[67] Program management dashboards The MassHealth Quality Office in collaboration with MassHealth stakeholders from different MassHealth programs is working to develop and implement several dashboards that would permit MassHealth managers to monitor their programs on key indicators and that would aid in identifying quality improvement goals. Dashboards under development include a multi-program Managed Care Dashboard, an Operations Dashboard, and a Medical Trends Report. The Managed Care Dashboard includes indicators that measure performance across multiple domains such as eligibility and enrollment, access and availability, cost of care, use of services, behavioral health, chronic care management, dental care, care integration, member satisfaction and services, program and data integrity. The initial measurement set is primarily based on nationally recognized measures, such as HEDIS®3. In addition to serving as a management tool for performance monitoring and improvement, the Managed Care Dashboard will also serve to promote transparency and standard measurement across MassHealth programs. State-level quality assessment MassHealth routinely collects HEDIS data from its managed care plans and periodically conducts patient experience surveys of managed care members. HEDIS and patient experience data are summarized in reports which are posted on the MassHealth website. Table 3 and Table 4 in Section 2B show the HEDIS and other measures collected by managed care entities and reported to MassHealth that relate to CMS core sets. Table 5 displays other HEDIS measures that MassHealth requires MCEs to collect (p. 10). MassHealth collects and reviews a substantial proportion of the CMS adult and child core performance measures as shown in Table 3 and Table 4. Only the Child and Adult Core measures are reflected in these tables. MassHealth uses a measure rotation approach to determining which measures will be included in each annual administration of HEDIS, so measures are not collected each year (p. 11). Managed Care Quality Improvement Goals (QI Goals) MassHealth requires Plans to conduct performance improvement projects, per State specifications of QI goals and measures. QI goals focus on five priority areas: population identification, access and availability, wellness and health promotion, disease management, and care management. The selected QI Goals measures and specifications are as consistent as possible with corresponding HEDIS indicators to minimize duplicity and resource burden on Plans and also to enhance comparability with national benchmarks. The QI Goals measurement cycle spans a 2-year period, with mid-cycle and final evaluation periods to allow for tracking of improvement gains. For the 2013-2014 cycle, MassHealth will measure the success of the Care Management Program by evaluating if the metrics and interventions are implemented as planned, yielding their intended results, and resulting in meaningful changes in health outcomes. Plans are required to submit baseline, mid-cycle and final written reports and host presentations regarding progress on QI goals for EOHHS staff at the end of each cycle. MassHealth has also initiated QI projects for measuring and improving care delivery and health outcomes for special needs populations. These include Reducing Disparities in Health Outcomes and patient-centered outcomes of enrollees in need of Complex Care Management interventions (p. 25). Adult Core Measure Grant In 2012, MassHealth was awarded a grant to develop staff capacity to collect, report, analyze and use data from the Initial Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Core Set). MassHealth will collect data and report on measures from the Adult Initial Core Set in both years of the grant and will include licensing HEDIS software to expand MassHealth's HEDIS measurement capacity. Additionally, this grant will enhance MassHealth's capacity to use quality measurement information. This may involve strategies of hiring analytic staff, designing targeting training programs for all staff working with data, and developing the skills to conducting drill-down analyses to uncover disparities. As part of this grant, MassHealth will also conduct two quality improvement projects (QIPs) related to the Initial Core Set. The QIPs topics focus on substance abuse and postpartum visits. The first QIP seeks to identify barriers and opportunities to behavioral health screening and the initiation and engagement of substance abuse treatment. The second QIP focuses on discovering and testing ways to improve post-partum visit rates among women who have recently given birth (p. 31, Massachusetts 2013 Medicaid Managed Care Quality Strategy)

[68] Objectives: 1.1: Deliver information that is clear, engaging, timely, accessible, and culturally and linguistically appropriate to our members and providers (p. 6). MassHealth participates in efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural backgrounds. All Plans ensure availability of multi-lingual providers and skilled medical interpreters for the commonly used languages in each community. Written information is available to enrollees in prevalent languages, as determined by the State. Prevalent languages are those spoken by 5% or more of MassHealth enrollees…MassHealth plans make available, free of charge, oral interpretation services in all non-English languages to assist enrollees with interpretation of all written materials provided to enrollees. Informational materials distributed to members via mail is accompanied by a babel card that indicates that the enclosed materials are important and should be translated immediately. The babel card also provides information on how the enrollee may obtain help with getting the materials translated (p. 17). Table 8: MCO QI Goal Interventions 2013-2014 Cycle…Design and implement one culturally appropriate care coordination strategy that takes into consideration the cultural diversity of the members seeking healthcare (p. 28, Massachusetts 2013 Medicaid Managed Care Quality Strategy).

[69] MassHealth Strategic Goals 2. Promote integrated care systems that share accountability for better health, better care, and lower costs; MassHealth Strategic Objectives 2.1 Use alternative payment methodologies to promote care delivery innovations such as team-based care, group visits, telehealth, virtual office visits, and community health workers (p. 6). Primary Care Payment Reform (PCPR) The Primary Care Payment Reform demonstration seeks to expand access to primary care, improve patient experience, quality, and efficiency through care management and coordination, and to incorporate behavioral health care with primary care. This initiative is designed to support primary care delivery by giving providers flexibility and the resources needed to deliver care and services. A primary care payment system that combines a shared savings/risk arrangement with quality incentives is currently in development by MassHealth. The proposed model will be designed to support primary care through a patient-centered medical home in collaboration with integrated behavioral health services (p.35). Health Homes Initiative Massachusetts is developing a Health Homes approach that is well coordinated and aligned with other health care reform and cost control measures. In particular, there will be strong connections between Health Homes and the Primary Care Payment Reform (PCPR) Initiative (p. 37, Massachusetts 2013 Medicaid Managed Care Quality Strategy).

[70] The Department requires MCOs to: Inform primary and specialty care providers of their responsibility to provide 24-hour per day, 7-day per week coverage (p. 20). MCOs must submit documentation that participants will have access to primary care services, including obstetrics/gynecology and diagnostic laboratory services, within a reasonable distance of their place of residence. (Urban areas: within a 10-mile radius; suburban areas: within a 20-mile radius; rural areas: within a 30-mile radius) (p. 21). MCOs must comply with specific participant-to-provider ratios for primary care within local access areas or counties, unless the MCO can establish to the Department's satisfaction that a higher ratio is adequate (p. 22). MCOs must assign each participant to the PCP the participant chooses from their panels or at the MCOs' selection if the participant fails to choose (p. 22, Maryland 2012 Medicaid Managed Care Quality Strategy).

[71] Million Hearts in Maryland set out to improve clinical and community linkages though the use of community health workers and community referrals (p. 36, Maryland 2012 Medicaid Managed Care Quality Strategy).

[72] The foundation of the plan hinges on providing a "medical home: for each participant, by connecting each participant with a primary care provider... The PCP is responsible for providing preventative and primary care services, managing referrals, and coordinating care for the participant (p. 1). Maryland's goal in implementing and continuing the demonstration is to improve the status of low-income Marylanders by: … Providing patient-focused, comprehensive, and coordinated care designed to meet the health care needs by providing each member a single "medical home" through a PCP (p. 6). The Department also conducts an EPSDT/Healthy Kids Program which requires all PCPs providing services under Medicaid to children and adolescents through 20 years of age with timely screening and preventative care (p. 7). In order for MCOs to properly serve special health care needs populations, the Department requires them to have the following mechanisms in place: A demonstration that its pediatric and adult primary care providers and specialists are clinically qualified to provide or arrange for the provision of appropriate health care... Demonstrate the use of a primary care system of care delivery, which includes a comprehensive plan of care for participants and uses a coordinated and continuous case management approach that involves the participant (and, as appropriate, the participant's family, guardian, or caregiver) in all aspects of care (p. 12). Service availability requirements: Develop PCP

treatment plans with participant participation, and in consultation with specialists, approve plans in a timely manner and in accordance with applicable Maryland Standards (p. 24). 1115 Waiver Primary Adult Care expanded to 116% FPL, piloted three-year program to test the use of a patient-centered medical home (p. 35). Due to the correlation between mental health and SUDs, the Department began a Behavioral Health Integration stakeholder process in CY 2011... After review of the various options, a cross-disciplinary leadership steering committee within the Department offered its recommendation that Maryland pursue a transformative behavioral health carve-out that combines treatment for specialty mental illness and SUDs under the management of a single administrative service organization (ASO) (p. 44, Maryland 2012 Medicaid Managed Care Quality Strategy).

[73] The Department requires MCOs to demonstrate the use of a primary care system of care delivery which includes a comprehensive plan of care for a participant who is a member of a special needs population and which uses a coordinated and continuous case management approach, involving the participant and, as appropriate, the participant's family, guardian, or caregiver, in all aspects of care, including primary, acute, tertiary, and home care. The Department also requires that MCOs document the plan of care and treatment modalities provided to participants in special populations, assuring that the plan of care is updated annually; involves the participant and, as appropriate, the participant's family, guardian, and caregiver in care decisions; and be familiar with community based resources available for the special populations (p. 28). Providers receive payments per member per month for performing care management activities related to preventive care and health promotion, coordination of care, disease self-management (p. 41). The MCO must demonstrate that enrollees are notified of educational programs and that they have been afforded the opportunity to evaluate these programs. The MCO must provide documentation in the form of notifications, attendance records and session evaluations. There must be evidence that providers are given the opportunity to evaluate enrollee educational sessions and the overall health education program. (p. 106, Maryland 2012 Medicaid Managed Care Quality Strategy).

[74] Because all Maryland MCOs are required to have or obtain NCQA accreditation as a condition of participating in HealthChoice, MCOs will be expected to collect and report the full roster of HEDIS® measures to the Department. The Department assesses and monitors MCO performance against national HEDIS® means and percentiles and against Maryland averages (p. 15). Health Information Technology Initiatives Supporting the Quality Strategy. Clinical Quality Reporting Maryland is implementing a streamlined clinical quality reporting strategy, which includes provider and EHR vendor use of the open-source software, popHealth. popHealth can integrate with a provider's EHR to report clinical quality measures to the HIE. The software allows for individual and state-level data dashboards on quality and empowers providers to understand and analyze their patient population's health, as well as meet meaningful use reporting objectives. As part of this strategy, Maryland developed a core set of quality metrics, which will allow for enhanced quality monitoring and improvement at the practice level. Initially, reporting requirements will only include claims-based measures. Requiring claims-based reporting will allow input from all practices without adding administrative burden. In the future, reporting requirements will expand to include clinically-enriched measures and clinical measures once CRISP is able to report them. Clinically-enriched measures differ from claims-based measures, as they incorporate lab values. Clinical measures are typically found in medical records rather than in claims. As of now, CRISP lacks functionality to report these types of metrics, but will be able to do so in the future. Currently, CRISP can access and report claims-based data through the all-payer claims database (APCD) or hospital utilization data (p. 41, Maryland 2012 Medicaid Managed Care Quality Strategy).

[75] Maryland provides applications via Maryland Health Connection in English and in Spanish. Spanish has been identified as the second most prevalent language following English among the HealthChoice population. The application also provides a call-in assistance number for individuals whose primary language is not English or Spanish (p. 12). The services and information must be provided in a culturally sensitive manner; at an appropriate reading comprehension level; in the prevalent non-English languages identified by the Department; and in a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 and all applicable regulations. MCOs must also make interpretation services available free of charge to each participant and potential participant who does not speak English or is hearing impaired (p. 21, Maryland 2012 Medicaid Managed Care Quality Strategy).

[76] The Medicaid Managed Care Performance Monitoring Specifications include a set of standardized metrics specific to them HMP population including timely completion of the initial health risk assessment and outreach/engagement to facilitate entry into primary care (p.11). Access Standards: Health plans are contractually obligated to make sure that primary care physicians provide or arrange for coverage of services 24 hours a day, 7 days a week. The health plan contract also states that primary care and hospital services must be available to enrollees within 30 minutes of travel or 30 miles, unless the enrollee choses otherwise (p. 25). To ensure adequate appointment access, contracted health plans are required to develop and comply with established standards for appointment availability and appointment wait time. Providers are also required to provide or arrange for coverage of services 24 hours per day, 7 days per week, and be present a minimum of 20 hours at each practice location (p. 26). Unique aspects of the HMP include the expectation that HMP enrollees contact their primary care physician within 60 days of enrollment to schedule an initial appointment (p. 58, Michigan 2015 Medicaid Managed Care Quality Strategy).

[77] Michigan provides comprehensive, continuous and coordinated care to Medicaid beneficiaries. Medicaid Health Plans are contractually responsible for coordinating and collaborating with local health departments and Children's Multidisciplinary Specialty (CMDS) Clinics to make a wider range of essential health care and support services available to enrollees (p. 29). Within the population health framework, MHPs must provide a broad spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and well-being... Population health management includes an overarching emphasis on health promotion as well as disease prevention. It also incorporated community-based health and wellness strategies focusing on the social determinants of health, creating health equity, and supporting efforts to build more resilient communities (p. 4). Michigan's population health model recognizes that population health management is built upon a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors, which impact health outcomes among different geographic locations and groups; the distribution of health conditions; and health-related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs. As a result, beginning in 2016 contracted health plans must develop and submit to MDHHS a multi-year plan to incorporate social determinants of health into their processes for analyzing data to support population health management. The plan is to include the manner in which the social determinant data will be collected and analyzed and how Contractor staff and embedded care managers will be trained on using the social determinants data. Data analysis must utilize available information such as claims, pharmacy, and laboratory results; supplemented by utilization data, health risk assessment (HRA) results and eligibility status (e.g., children in foster care, persons receiving Medicaid for the blind or disabled, CSHCS). The goal is to address health disparities, improve community collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees. Target populations may include those experiencing a disparate level of social needs such as transportation, housing, food access, unemployment or education level. Subpopulations may include individuals with poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, geographic location or income level. Contracted health plans must also participate in initiatives to develop a core set of social determinants of health indicators; identify community-based support services and monitor utilization of these services as well as health outcomes; and report on the effectiveness of its population health management initiatives. Intervention strategies may include in-person support services such as Community Health Workers (CHW), patient navigators, home visiting programs (MIHP), or health promotion or preventions programs delivered by a community-based organizations (adult/family shelters, schools, foster homes) (p. 14-15). Plans must also refer enrollees to and coordinate services with appropriate resources to reduce socioeconomic barriers and address social determinant of health (e.g., access to safe and affordable housing, employment, food, fuel assistance and transportation to health care appointments) (p. 33). he health plans are required to establish and maintain coordination of care agreements with the local behavioral health and developmental disability agencies (CMHSPs) for behavioral health and developmental disability services (p. 26). Requirements in the FY 2016 Medicaid Health Plan contract are intended to provide opportunities to meet these challenges through the following activities: Incorporation of social determinants of health into data analyses for populations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment or education level... Integration of behavioral health services into primary care and

community health center... Supporting the expansion and transformation of primary care practices into patient-centered medical homes (PCMH) and committing to increasing the percentage of enrollees receiving services from PCMH-designated practices (p. 65, Michigan 2015 Medicaid Managed Care Quality Strategy).

[78] Medicaid Health Plans must fully participate with... the expansion of patient-centered medical homes (p. 4). MDHHS allows a physician specialist to function as a Primary Care Provider (PCP) in cases where the enrollee's medical condition warrants this arrangement (p. 26). Plans are also contractually responsible for the coordination and continuity of care provided to enrollees who require integration of medical, behavioral health and/or substance abuse services. Section 1.022(F)(18) of the Medicaid Health Plan contract specifies that plans must demonstrate a commitment to case managing the complex needs of enrollees and support the physician-patient relationship in the development of plans of care, which must take into account all of an enrollee's needs (e.g., home health services, therapies, durable medical equipment and transportation). Plans must submit evidence of care coordination to MDHHS upon request. During the annual on-site visit, MDHHS assesses the continuity of the coordination of care and case management processes. In addition, continuity and coordination of care are components of the mandatory health plan accreditation process; plans must meet or exceed established standards to maintain accreditation status CSHCS enrollees must be assigned to PCP's that have attested to being willing care for the potentially complex health conditions of the population and provide family-centered care. Prior to mandatory enrollment of CSHCS in managed care, health plans were required to submit policies and procedures to demonstrate effective care coordination for this population (p. 29). MDHHS recognizes the need to support a robust primary care delivery system based on a patient centered medical home (PCMH) model to ensure patient care is managed across a continuum of care and specialty services will be accessed as appropriate. Contracted health plans are expected to develop initiatives to promote and support PCMH adoption among primary care providers and commit to increasing the percentage of enrollees receiving services from PCMH-designated practices (e.g., National Committee for Quality Assurance or Blue Cross Blue Shield of Michigan's Provider Group Incentive Program) (p. 49). MDHHS recognizes the importance of integrating both physical health and behavioral health services to effectively address enrollee needs and improve health status. To meet this goal, health plans are required to work with MDHHS to develop initiatives to better integrate services covered by the Contractor and the Prepaid Inpatient Health Plans (PIHP) serving Contractor's enrollees and to provide incentives to support behavioral health integration (including shared metrics hospitalization follow up, access to community health workers and peer support specialists, and online information sharing) (p. 30). Contracted health plans are required to provide case management, care coordination, and disease management to meet the complex health care needs of enrollees, including but not limited to those with special health care needs, disabled populations, high-risk pregnancy, and children with elevated blood lead. These services must be operationally integrated into the Contractor's utilization management and enrollee services (p. 33). This CMS Multi-Payer Advanced Primary Care Demonstration Project is the largest in the county and seeks to expand primary care and improve care coordination in patient centered medical homes (p. 50). PCMH expansion supports population health management concepts including person-centered care, and care coordination/case management. Plans must coordinate with practice-based care management and Michigan Primary Care Transformation (MiPCT) care managers for enrollees and report semi-annually on the percentage of primary care practices with embedded or shared care managers (p. 49-50). support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness... (p. 51). In the past year, the MDHHS has taken action to improve the coordination of physical and behavioral health care by expanding the exchange of electronic health records to providers (p. 52, 55). Contractors must also fully participate with MDHHS-directed initiative to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social services needs are served by person-centered models across all health care domains (p. 4). Key concepts: Focus on social determinants of health... Value-based strategies including patient centered medical homes, shared savings, accountable systems of care/accountable care organizations, episodes of care, value purchasing... Integration and coordination across all health care domains to improve care for individuals... Clear expectations for behavioral health in primary care (p. 5). Adult Core Set Measures: Care Coordination (p. 16, Michigan 2015 Medicaid Managed Care Quality Strategy).

[79] Table 1: Michigan's vision: Create a managed care system that maximizes the health status of enrollees through evidence- and value-based care delivery models…key concepts…Person-centered care, personal engagement and responsibility (p. 5). Other key features include incentives for healthy behaviors to encourage personal responsibility (p. 7). Michigan Medicaid Managed Care Program Goals…Improve enrollee engagement (p. 9). Another new component in 2015 is the requirement that health plans provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to enrollees who have significant behavioral health issues and complex physical co-morbidities… Examples of CHW services include… helping enrollees with self-management skills (p. 30). MDHHS designs and implements quality improvement interventions based on assessment findings... To date, Michigan has identified and is focusing on the following topics… patient engagement (p. 44). Michigan Medicaid is actively participating in MiPCT and partnered with Medicare, Blue Cross Blue Shield of Michigan, Blue Care Network, and Priority Health to create a multi-payer bonus to incentivize physicians to fully implement the PCMH model…Focus areas …self-management support (p. 50). MHP staff will conduct outreach and engagement activities, educate, and coordinate services for enrollees with a focus on social determinants of health (p. 54). Key features include incentives for healthy behaviors to encourage personal responsibility (p. 57). Michigan is striving to align the state's Quality Strategy with National Quality Strategy (NQS). … The NQS is organized … six priorities … ensuring that people and families are engaged as partners in care (p. 65, Michigan 2015 Medicaid Managed Care Quality Strategy).

[80] The purpose of the Medicaid Health Equity Project is to promote health equity by establishing a system to monitor racial and ethnic disparities within the managed care population. The Project also allows MDHHS to identify priority areas for quality improvement initiatives related to health disparities. All contracted health plans submitted data in reporting year 1 (2011),which were analyzed and reported in both plan-specific and statewide reports. Six additional measures were added in year 2 (2012) for a total of 14 measures. These measures with the addition of a fifteenth measure, "Race/Ethnicity by Diversity of Membership" were reported in 2013 and 2014 using the same submission process. As a means of measuring quality consistently across plans and to facilitate comparison across states, the plans submit audited Health Effectiveness Data and Information Set (HEDIS) data to MDHHS for each measure that pertains to Medicaid covered benefits. Data for Healthy Michigan Plan beneficiaries are included in the health plan HEDIS data and associated activities to reduce health care disparities. Pairwise disparities are measured between the non-white populations and the reference (White) population. For each indicator, population disparity was estimated with an Index of Disparity (ID), which describes average subpopulation variation around the total population rate. The ID is being used to identify measures where quality improvement is needed to ensure health equity for the Medicaid managed care population. The following subset of HEDIS measures broken down by race/ethnicity are submitted by contracted health plans for the Health Equity Project: Women-Adult Care and Pregnancy, Child and Adolescent Care, Access to Care, and Living with Illness (p. 13-14). Beginning in 2016 contracted health plans must develop and submit to MDHHS a multi-year plan to incorporate social determinants of health into their processes for analyzing data to support population health management. The plan is to include the manner in which the social determinant data will be collected and analyzed and how Contractor staff and embedded care managers will be trained on using the social determinants data. Data analysis must utilize available information such as claims, pharmacy, and laboratory results; supplemented by utilization data, health risk assessment (HRA)results and eligibility status (e.g., children in foster care, persons receiving Medicaid for the blind or disabled, CSHCS). The goal is to address health disparities, improve community collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees. Target populations may include those experiencing a disparate level of social needs such as transportation, housing, food access, unemployment or education level. Subpopulations may include individuals with poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, geographic location or income level. Contracted health plans must also participate in initiatives to develop a core set of social determinants of health indicators; identify community-based support services and monitor utilization of these services as well as health outcomes; and report on the effectiveness of its population health management initiatives. Intervention strategies may include in-person support services such as Community Health Workers (CHW), patient navigators, home visiting programs (MIHP), or health promotion or preventions programs delivered by community-based organizations (adult/family shelters, schools, foster homes) (p. 14-15). National Performance Measures MDHHS continues to strengthen capacity to generate and report the Adult

Core Set Measures and is actively participating in AMQ activities in measurement development and revision. Michigan will continue to report the Adult Core Set Measures and establish performance goals following baseline analyses (p.1 7). In addition to the Adult Core Set Measures, Michigan reports on the following Child Measures for the Medicaid population: access to care, preventive care, maternal and perinatal health, behavioral health, care of acute and chronic conditions, and experience of care. Performance goals have been established for a [number of the] Child Core Set Measures (p. 18). Section IV: Improvement and Interventions MDHHS designs and implements quality improvement interventions based on assessment findings (i.e., HEDIS, CAHPS, performance improvement projects, EQR, performance monitoring standards, on-site reviews, health equity projects, and adult and child quality measures). To date, Michigan has identified and is focusing on the following topics: Primary care delivery (prevention, access, care coordination, Patient-Centered Medical Home, patient engagement, integration of mental health services) (p. 44, Michigan 2015 Medicaid Managed Care Quality Strategy).

[81] Federal regulations require that MHPs provide services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Disparities assessment, identification, and reduction have been priorities for Michigan Medicaid for several years (p. 13). health plans must address the need for culturally appropriate interventions and make reasonable accommodations for enrollees with hearing and/or vision impairments including those with limited proficiency in English. Oral interpretation services must be available free of charge to all enrollees (Section 1.022 (H)(1)) (p. 38, Michigan 2015 Medicaid Managed Care Quality Strategy).

[82] Payment Reform Paying for value is an integral component of Michigan's strategy to improve the health and well-being of Medicaid beneficiaries. Key strategies include aligning payment around improving population health outcomes, member experience, and controlling cost. MDHHS is committed to moving away from fee-for-service (FFS) models and embracing accountable and transparent payment structures that reward and penalize based on defined performance metrics. Value-based payment models are defined as those that reward providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries. Value-based payment models may include, but are not limited to: total capitation models, limited capitation models, bundled payments, supplemental payments to build practice-based infrastructure and enrollee management capabilities and payment for new services that promote more coordinated and appropriate care, such as care management and community health work services that are traditionally not reimbursable. Consistent with MDHHS's policy to move reimbursement from FFS to value-based models, beginning in 2016 MHPs are contractually required to increase the total percentage of health care services reimbursed under value-based contracts. Medicaid Health Plans must fully participate with MDHHS-directed initiatives to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social service needs, are served by person- centered models across all health care domains. MDHHS encourages the plans to propose and pilot innovative payment reform projects. Key concepts include performance bonuses linked to outcomes (e.g., reducing inappropriate ED use); common performance metrics (e.g., physical and behavioral health); value-based strategies (e.g., Patient Centered Medical Homes, leveraging health plan provider contracts to promote reform, shared savings); accountable systems of care/accountable care organizations; value purchasing; and payment and delivery system reform at the provider level. Payment reform is also a central feature of the Healthy Michigan Plan. The HMP rewards providers for outcomes, including improving the quality of services provided, promotes provision of appropriate services, and aims to reduce the total cost of services provided to Medicaid beneficiaries. Key HMP concepts include: the advancement of health information technology; structural incentives for healthy behaviors and personal responsibility; and promoting the overall health and well-being of Michigan citizens. The Managed Care Common Formulary also supports payment transformation and reduces drug costs through standardized drug coverage policies and reducing administrative burden for beneficiaries and providers (p. 58-59, Michigan 2015 Medicaid Managed Care Quality Strategy).

[83] The MCO must furnish on its web site a complete provider directory including the names and locations of primary care providers, hospital affiliations, whether providers are accepting new patients, languages spoken in the clinics, how to access behavioral health services, and other important information (p. 31, Minnesota 2018 Medicaid Managed Care Quality Strategy).

[84] Project goals include: Systematized screening, care coordination, referral, and follow up for behavioral and social risks known to be associated with poor birth outcomes and prevalent within the targeted populations, such as substance abuse, homelessness, domestic violence and abuse, chronic mental illness, and poorly developed self-care knowledge and skills (p. 12). Some examples of current IHP health equity interventions include: community collaborative to fight food insecurity, integration of behavioral and physical health to support adolescents who screen positive for depression, and an opioid management program (p. 13, Minnesota 2018 Medicaid Managed Care Quality Strategy).

[85] The Opioid Prescribing Improvement Program is a statewide initiative proposed in the 2015 legislative session. The program's goal is to reduce the opioid dependency and substance use of Minnesotans due to or related to the prescribing of opioid analgesics by health care providers. This program is a collaborative effort between the Department of Human Services (DHS) and Minnesota Department of Health (MDH), building upon recommendations made by DHS' Health Services Advisory Council (HSAC), DHS' Emergency Department Utilization Work Group, and other community initiatives. This program (upon legislative approval and implementation) will allow DHS, MDH, and the larger provider community the opportunity to build on and synergize existing quality improvement efforts among health systems, other provider groups, and professional associations. The most immediate hurdle is receiving support and passing this proposed legislation (p. 10-11). Integrated Care for High Risk Pregnant Women. Adverse birth outcomes result in high care costs due to intensive treatment requirements for newborns, related to prematurity, low birthweight, and maternal substance abuse, especially opiates. The proposed program will target resources for prenatal prevention and treatment to improve birth outcomes…. Participating mothers will be connected to existing maternal health and substance abuse services through community and public health programs. The program will work with community organizations, lay and professional providers to develop local systems of care that are community held, community monitored and maintained with appropriate state oversight. Participating clinics will include tribal health providers and community clinics; local public health and social service agencies; and substance abuse treatment providers (p. 11-12). Behavioral Health Homes (BHH) Initiative is Minnesota's version of the federal "health home" benefit for Medical Assistance (MA) enrollees. BHH is a DHS project, jointly managed by the Health Care Administration and the Community Supports Administration (Adult and Children's Mental Health). Behavioral Health Home services will be made available to the following MA enrollees: Adults with serious mental illness, adults with a serious and persistent mental illness; and children and youth experience a severe emotional disturbance. Behavioral health homes will: use a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care; better meet the needs of individual's physical, mental, substance use and wellness goals; take a person-centered approach, and engage and respect individuals and families in their health care, recovery and resiliency; and respect, assess and use the cultural values, strengths, languages, and practices of individuals and families in supporting an individual's health goals. BHH likely candidates include community mental health centers, pediatric clinics, and fully integrated primary care clinics (p. 15-18). Evidence suggests that better coordination and integration of primary and behavioral health care will result in: improved access to primary care services; improved prevention, early identification and intervention to reduce the incidence of serious physical illnesses including chronic disease; and increased availability of integrated holistic are for physical and behavioral disorders as well as better overall health status for individuals. Behavioral health homes services will begin in July, 2016 contingent upon federal approval (p. 16). A significant feature of the MSHO program is the provision of care coordination assigned to each MSHO enrollee upon initial enrollment. Each MSHO enrollee is assigned a care coordinator upon initial enrollment. Care coordinators assist enrollees in navigating the health care system and work with them to ensure that care is provided in appropriate settings (p. 29). The MSHO and SNBC contract specify detailed care coordination requirements that hold the care coordinator/health coordinator/navigation assistant responsible for coordinating care including assurances that enrollees have an ongoing source of primary care. Under these programs a care plan is developed that combines the primary care, chronic disease management and long-term needs including HCBS. Care plan development involves the enrollee's participation to the extent possible according to the enrollee's health status (p. 35). Treatment and recovery services [for pregnant and parenting women in substance abuse treatment] include: … Comprehensive needs assessments and individualized care plans (p. 176). Behavioral health homes provide integrated medical care for adults with serious and persistent mental illness, and children with emotional disturbance. Recipients receive comprehensive care management through a collaborative process designed to more effectively manage medical, social, and behavioral health conditions. Providers draft a patient-centered action plan based on a

template developed by the state Medicaid agency. The plan requires providers to maintain regular contact with the recipient, coordinate services among other providers involved in the recipient's care, and monitor progress towards achieving the goals outlined in the plan. When the recipient is child, all activities must include the consent of the child's parent or guardian. All Behavioral Health Homes are certified by the state. These providers include: Integration specialists (which include registered nurses, and mental health professionals); Behavioral Health Home Navigators (which include case managers and mental health professionals); Qualified Health Home Specialists (including community health workers, peer specialists, and certified health education specialists); and other specialists as necessary (p. 160, Minnesota 2018 Medicaid Managed Care Quality Strategy).

[86] Appendix C: DHS Supplemental Triennial Compliance Assessment Elements (p.49). NCQA Standard QI 4: Member Experience. (p.52) Annual Quality Assessment and Performance Improvement Program Evaluation - 2017 Contract Section 7.1.81920 A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards and Guidelines for Accreditation of Health Plans." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standard measures (example: HEDIS®) and MCO's performance improvement projects. (p.55). Appendix I: Ongoing DHS Performance Measurement. Calculated annually by DHS using claims data submitted to the State by MCOs. Table 1: HEDIS Performance Measures. Measure # 1: Adults' Access to Preventative/Ambulatory Health Services (20-44, 45-64, 65+ years & Total); Measure #3: Annual Dental Visit (2-3, 4-6, 7-10, 11-14, 15- 18, Total for children, 2-18, 19-21, 22-64, 65+, & Total for adults 19+); Measure #7: Adolescent Well-Care Visits (12-21 years); Measure #9: Children and Adolescents' Access to Primary Care Practitioners (12-24 months, 25 months-6 years, 7-11 years, 12-19 years, & Total); Measure #26: Well-Child Visits First 15 Months (zero, 1, 2, 3, 4, 5, 6 or more visits); Measure #27: Well-Child Visits (3 – 6 years) (p. 156-157, Minnesota 2018 Medicaid Managed Care Quality Strategy).

[87] DHS strives to achieve results in seven essential outcomes through its Medicaid Managed Care Comprehensive Quality Strategy…focus health care improvements on enrollee demographics and cultural needs (p. 7). Respect, assess and use the cultural values, strengths, languages, and practices of individuals and families in supporting an individual's health goals (p. 17). Inclusion of individual, cultural, spiritual and gender values into the care process" in the behavioral health homes model (p. 18). provider directories must also include cultural competency training and handicap accessibility indicators (p. 31, Minnesota 2018 Medicaid Managed Care Quality Strategy).

[88] Delivery System and Payment Reform: Value-Based Payment Program. The MN DHS value-based purchasing initiative is called the Integrated Health Partnership (IHP) program. The IHP program uses direct contracts with providers to enhance accountability through shared savings and shared risk, creating incentives for quality improvement. The program operates across both fee-for-service and managed care (under 65 non-duals). The IHP model (IHP Legacy) has been in operation since 2013. Beginning in 2018, DHS launched IHP 2.0 which includes a population-based payment which all IHP 2.0 participants (both Tracks 1 and 2) receive and a total cost of care risk-based payment that only Track 2 IHP 2.0 participants may receive. IHP 2.0 Track 1 – Population Based Payment For the purpose of the population-based payment in tracks 1 and 2, IHPs are evaluated on health equity, quality, and utilization measures to determine eligibility to continue participation after the conclusion of each three-year cycle. Each IHP is required to design interventions to address social risk factors and health disparities. The health equity measures gauge the effectiveness of each intervention and IHP's cooperation with community partners. These equity measures are agreed to upon review of DHS-produced data. These data demonstrate the prevalence of social risk factors and the prevalence of correlated negative health outcomes among IHP-attributed population of patients. Some examples of current IHP health equity interventions include: community collaborative to fight food insecurity, integration of behavioral and physical health to support adolescents who screen positive for depression, and an opioid management program. IHP 2.0 Track 2 – Total Costs of Care For the purpose of the total costs of care model in track 2, IHPs are evaluated on a core set of measures to determine how much shared savings an IHP receives. In each demonstration year fifty percent of IHP's portion of shared savings is contingent on its overall quality score. The overall quality score is calculated based on IHP performance on measures organized into the following categories: Care Quality (Prevention & Screening; Effectiveness of Care for at Risk Populations, Behavioral Health; Access to Care; Patient-centered Care; Patient Safety), Health Information Technology (Meaningful Use of EHR: Care Coordination objective and Health Information Exchange objective), and Pilot Measures (e.g. patient engagement, care coordination, opioid use or specialty measures) (p. 13-14). See Appendix J: Directed Payment Arrangements for more information (p. 159-160, Minnesota 2018 Medicaid Managed Care Quality Strategy).

[89] Show-Me ECHO (Extension for Community Healthcare Outcomes) is part of the University of Missouri's Telehealth Network. Show-Me ECHO uses videoconferencing technology to connect a team of interdisciplinary experts with primary care providers. The discussions with, and mentoring from, specialists help equip primary care providers to give their patients the right care, in the right place, at the right time (p. 10). Goal 1: Ensure appropriate access to care. Objective 1: Ensure timely access to care. Measures: Percentage of Primary Care Provider offices that met the urgent appointment standard (24 hours for illness or injury requiring immediate care). Percentage of Primary Care Provider offices that met the routine appointment standard (30 days for routine care without symptoms). Objective 2: Ensure an adequate healthcare network. Measures: Percentage of primary care physician offices that meet mandated access standards (p. 25). Goal 4: Promote member satisfaction with experience of care. Objective: Promote access to care. Measures: Rate of always or usually getting needed care as soon as needed within the last six months; Rate of always or usually getting care quickly within the last six months (p. 26, Missouri 2018 Draft Medicaid Managed Care Quality Strategy).

[90] All MCOs are required to participate in community health improvement initiatives in collaboration with the DHSS and local public health agencies (p. 8). MO HealthNet's Primary Care Health Home (PCHH) Program strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population through providing clinical care and wrap around services (p. 9, Missouri 2018 Draft Medicaid Managed Care Quality Strategy).

[91] All MCOs are required to participate in community health improvement initiatives in collaboration with the DHSS and local public health agencies (p. 8). The care management requirements are comprehensive and have evolved over time as newer data from MHD program evaluations have emerged to inform these requirements. Part of that evolution is the incorporation of the principles used in the MHD Section 2703 Health Home Program... In addition to incorporating those principles, within the Managed Care contract, MCOs are historically required to assess members for care management within a specified number of days after enrollment or diagnosis with specific conditions and/or risk factors (p. 9). In addition, MCOs are required to ensure collaboration with the MHD Section 2703 Health Homes Program for their members. MO HealthNet's Primary Care Health Home (PCHH) Program strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population through providing clinical care and wrap around services. One aspect of the program includes the implementation and evaluation of the Patient Centered Medical Home model as a means to: a) achieve accessible, high quality primary care, b) Demonstrate cost effectiveness in order to validate and support the sustainability and spread of the model and c) Support primary care practices by increasing available resources and improving care coordination thus improving the quality of clinician work life and patient outcomes (p. 9-10). The PCHH initiative offers comprehensive care management services for Medicaid participants who have two or more chronic health conditions including asthma/COPD, developmental disabilities, diabetes, cardiovascular disease, overweight/obesity, substance use disorder, depression, anxiety, and tobacco use. The program also emphasizes the integration of primary care and behavioral health care in order to achieve improved health outcomes (p. 10). Community Mental Health Centers (CMHCs) providing community psychiatric rehabilitation services are recognized by the Missouri Department of Mental Health to serve as CMHC Health Homes under Section 2703. CMHC Health Homes assist individuals in accessing needed health, behavioral health, and social services and supports; managing their mental illness and other chronic conditions; improving their general health; coordination with primary care; and developing and maintaining healthy lifestyles (p.10). The third is the creation of a Local Community Care Coordination Program (LCCCP), which is another evidence-based patient-centered concept that incorporates MHD's Health Homes Program principles, thus providing a unified paradigm across the Division and its programs. LCCCPs have the following components: Every member has a PCP; Care is provided by a physician-directed team that collectively cares for the member; Care is coordinated across all aspects of health care;

Member Care Management includes care coordination, health promotion, transitional care, individual and family support activities, disease management, and referrals to local social support resources (p. 11, Missouri 2018 Draft Medicaid Managed Care Quality Strategy).

[92] One of the guiding principles in the Managed Care Program is the Medicaid Reform and Transformation Program. This principle is supported through contract provisions that require the MCOs participate in three different types of initiatives. First are member incentive programs that encourage personal responsibility related to health behaviors and outcomes (p. 11, Missouri 2018 Draft Medicaid Managed Care Quality Strategy).

[93] Performance Improvement Projects. Each health plan must conduct Performance Improvement Projects (PIPs) aimed at improving clinical and nonclinical care of their members. The state agency requires that the MCOs measure performance using objective quality indicators (typically, they use HEDIS measures), implement interventions designed to achieve improvement in quality, evaluate the effectiveness of their interventions, and make plans to sustain or increase improvement over time. PIPs are typically aimed at showing improvement within each contract year. The MCOs are all required to participate in two statewide PIPs that have been selected by the MHD to align with specific agency goals and priority areas. The two statewide PIPs, both measured using HEDIS, are: Improving the rate of immunizations for members by their second birthday (p. 27, Missouri 2018 Draft Medicaid Managed Care Quality Strategy).

[94] During the application process, the applicant identifies race, ethnicity, and primary spoken language. The Managed Care contract includes language requirements compliant with Federal regulations. The MCOs are notified of member enrollment/disenrollment information via a nightly enrollment file and a weekly enrollment reconciliation file. To facilitate care delivery appropriate to member needs, the enrollment file also includes race, primary language spoken, and selective health information. The MCOs utilize information on language to provide interpretive services, develop educational materials for employee training, and facilitate member needs in the context of their language requirements (p. 14, Missouri 2018 Draft Medicaid Managed Care Quality Strategy).

[95] MississippiCAN is a statewide coordinated care program designed to meet the following managed-care goals: Improve access to necessary medical services by connecting beneficiaries with a medical home, increase access to health-care providers and improving beneficiaries' use of primary and preventative care services (p.5); Access Standards. PCPs (Adult and Pediatric): Urban – Two within 15 miles; Rural – Two within 30 miles. General Dental Providers (Adult and Pediatric): Urban – One within 30 minutes or 30 miles; Rural – One within 60 minutes or 60 miles (p. 14). Appointment wait times. PCP (Well Care Visit): Not to exceed 30 calendar days; PCP (Routine Sick Visit): Not to exceed 7 calendar days; PCP (Urgent Care Visit): Not to exceed 24 hours; Dental Providers (routine visits): Not to exceed 45 calendar days; Dental Providers (Urgent Care): Not to exceed 48 hours (p. 15, Mississippi 2018 Draft Medicaid Managed Care Quality Strategy).

[96] MississippiCAN is a statewide coordinated care program designed to meet the following managed-care goals: Improve quality of care and population health by providing systems and supportive services, including care coordination, care management and other programs that allow beneficiaries to take increased responsibility for their health care (p. 5, Mississippi 2018 Draft Medicaid Managed Care Quality Strategy).

[97] MississippiCAN is a statewide coordinated care program designed to meet the following managed-care goals: Improve quality of care and population health by providing systems and supportive services, including care coordination, care management and other programs that allow beneficiaries to take increased responsibility for their health care (p. 5, Mississippi 2018 Draft Medicaid Managed Care Quality Strategy).

[98] Quality and Appropriateness of Care DOM has ongoing quality assessment and performance improvement strategies to ensure the delivery of quality health care to MississippiCAN and MississippiCHIP beneficiaries. Performance Measures DOM has adopted the majority of the National Adult and Child Health Quality Measures, along with state-specific performance measures and focused topics for required Performance Improvement Projects (PIPs). These state-mandated measures and projects address a range of priority issues for Mississippi Medicaid populations. The measures have been identified through a process of data analysis and evaluation within these populations. Performance goals are based on improvement to or maintenance of the following benchmarks: Healthcare Effectiveness Data and Information Set (HEDIS) 25th, 50th and 75th percentiles, and Consumer Assessment of Healthcare providers and Systems (CAPHS) Quality Compass national benchmark. See Appendix E for the Adult and Child Health Quality Measures (p. 10). Appendix E: Adult and Child Quality Measures Child Health Quality Measures (examples): Childhood Immunization Status, Adolescent Immunization Status, Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents, Well-Child Visits/Adolescent Well-Care Visits and Child and Adolescent Access to Primary Care Practitioners. Adult Quality Measures (examples): Adult BMI assessment, Follow-Up After Hospitalization for Mental Illness, Controlling High Blood Pressure, and Comprehensive Diabetes Care (Appendix E, Mississippi 2018 Draft Medicaid Managed Care Quality Strategy).

[99] The CCO provider network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency (p.17, Mississippi 2018 Medicaid Managed Care Quality Strategy).

[100] MCO must ensure that coverage is available to enrollees on a twenty-four hours a day, seven days a week basis. MCO must ensure that network providers offer hours of operation that are no less than those offered to commercial enrollees (p. 13). The primary care network must have at least one full-time equivalent Primary Care Provider (PCP) for every 2,500 patients, including Medicaid expansion enrollees; A ratio for each High Volume and High Impact Specialist type (see definition above) of one full time equivalent physician per 3,000 enrollees; A ratio for each High Volume Behavioral/Mental Health and Substance Use Disorder Practitioner type (see definition above) of one full time equivalent practitioner per 3,000 enrollees; MCO must incorporate access standards developed jointly by MCO and the STATE. MCO must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist (p. 13-14). MCO must provide a clinically appropriate primary care provider with the skills and experience to meet the needs of enrollees with special health care needs. MCO shall allow an appropriate specialist to be the PCP but only if the specialist has the skills to monitor the enrollee's preventative and primary care services (p. 16). MCO must provide access to ensure that each enrollee has an ongoing source of primary care providers appropriate to his or her needs. Enrollees are encouraged to select their PCP but, the enrollee is not required to select a PCP (p. 17, North Dakota 2017 Medicaid Managed Care Quality Strategy).

[101] The guiding principles and expected outcomes have been developed and include the following: Improved coordination of care (p. 4). Enrollees with Special Health Care Needs. Enrollees with special health care needs are those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by enrollees, generally. MCO shall ensure there is access and care coordination to all services to meet the health needs of enrollees with special health care needs in accordance with the covered services, limitations, and exclusions (p. 7). The PCP is responsible for overall clinical direction and, in conjunction with the Care Coordinator, serves as a central point of integration and coordination of covered services, including primary, acute care, and behavioral health services (p. 15). MCO must furnish a Service Coordinator to all Medicaid enrollees who request one. MCO should also furnish a Care Coordinator to an enrollee when MCO determines one is required through an assessment of the enrollee's health and support needs (p. 16, North Dakota 2017 Medicaid Managed Care Quality Strategy).

[102] The guiding principles and expected outcomes have been developed and include the following... Outreach and education to promote healthy behaviors…Increased personal responsibility and self-management (p. 4-5, North Dakota 2017 Medicaid Managed Care Quality Strategy).

[103] Guiding Principles and Expected Outcomes The guiding principles and expected outcomes have been developed and include the following: Increased quality of care as measured by metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS) (p. 5). Appendix A – ND Medicaid Expansion Quality Indicators (Adult and Child Measures) (p. 33-39, North Dakota 2017 Medicaid Managed Care Quality Strategy).

[104] Medical Services Division has adopted a framework of quality and strives for its enrollees to receive care that is… Equitable: providing programs/services and care without variation in quality due to gender, ethnicity, geographic location, and socioeconomic status (p. 4). Information about the race, ethnicity, and primary language of enrollees is collected by eligibility workers at local county social services offices and the medical facility staff during the enrollment process. This information is self-reported by the individual and optional on the application or redetermination form. As provided by the individual, county and state staff enter the information into the SPACES system (North Dakota's eligibility system) along with the individual's other enrollment application information. MCO shall utilize the top 15 languages spoken by individuals with limited English proficiency in North Dakota that indicate the availability of language assistance in accordance with guidance issued under Section 1557, CMS, HHS, and HHS OCR. The MCO shall ensure that translation services are provided for written marketing and enrollee education materials for the top 15 languages spoken by individuals with limited English proficiency in ND, as applicable. The STATE requires that MCO and any contractors have oral interpretive services for those who speak any foreign language (p. 7). MCO must provide all enrollee notices, information materials, and instructional materials in a manner and format that may be easily understood, in accordance with 42 CFR §438.10. This includes ensuring capacity to meet the needs of limited English proficient groups in their service areas and making available materials in alternative formats upon request. Materials and enrollee handbooks are designed to assist enrollees and potential enrollees in understanding the Health Plan programs, addressing program features, including: benefits, cost sharing, service areas, provider network characteristics, and policies and procedures concerning enrollee rights and protections (p. 24, North Dakota 2017 Medicaid Managed Care Quality Strategy).

[105] When establishing and maintaining the network, the MCO/DBPM must consider: The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities (p. 18). The MCO must provide an adequate network of PCPs to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP and must have the opportunity to seek a second opinion from a qualified health care professional. Provider types that can serve as PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (ob/gyn). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license. The MCO must also share with other MCOs that serve members with SHCNs the results of identification and assessment to prevent duplication of services (p. 18). Wait times for scheduled appointments should not routinely exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment (p. 19). Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards (p. 20). The MCO/DBPM must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When a gap is identified, the MCO/DBPM must document its efforts to engage any available providers (three good-faith attempts, for example) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time (p. 20). The MCO/DBPM must establish a program of assertive outreach to rural areas where covered services may be less available than in urban areas and must include any gaps in its availability plan. The MCO/DBPM must monitor utilization across the state to ensure access and availability, consistent with the requirements of the contract and the needs of its members (p. 20). MLTC's enrollment broker is required to send to the MCO a daily electronic transmission file that contains the names, addresses, and telephone numbers of all members newly assigned to the MCO, with an indicator for members who were auto-assigned. The MCO must use this file to identify new members, initiate communication with new members via welcome packet mailings and calls, and assign members to a PCP, if the member has not already chosen one. At initial enrollment, if an enrollee selects an MCO and a PCP, the assignment of the PCP will be included on the enrollment file sent to the MCO. If no PCP selection is indicated on the enrollment file, the MCO must contact the member to assist with selecting a PCP within ten (10) business days of receipt of the enrollment file and assign a PCP within one (1) month of the enrollment date a PCP is not chosen (p. 22). The DBPM's (Dental Benefits Program Manager) responsibilities subsequent to eligibility determination will include, but will not necessarily be limited to, the following: Being available by telephone to provide assistance to DBP potential members, and educating the Medicaid eligible about the DBP in general, including the manner in which services typically are accessed under the DBPM, the role of the dental home, the responsibilities of the DBPM member, his/her right to file grievances and appeals, and the rights of the member to choose any dental home within the DBPM, subject to the capacity of the provider; Educating the member, or in the case of a minor, the member's parent or guardian, about benefits and services available through the DBPM; Identifying any barriers to access to care for members such as the necessity for multi-lingual interpreter services and special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities (p. 23). Appointment Availability Access Standards. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO; Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation; Non-urgent, preventive care must be available within 4 weeks; PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week (p. 62). Geographic Access Standards. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties (p. 62). DBPM Waiting Times and Timely Access. Urgent Care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)]; Urgent care may be provided directly by the primary care dentist or directed by the DBPM through other arrangements; Routine or preventative dental services within six (6) weeks; Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment (p. 63). Geographic Access Standards. The DBPM must, at a minimum, contract with two (2) dentists within forty-five (45) miles of the personal residences of members in urban counties; one (1) dentist within sixty (60) miles of the personal residences of members in rural counties; and one (1) dentist within one hundred (100) miles of the personal residences of members in frontier counties (p. 63, Nebraska 2017 Medicaid Managed Care Quality Strategy).

[106] By requiring MCOs to collaborate with other entities and programs that serve the needs of MMC members, Heritage Health can more effectively promote quality of care, utilizing the resources of these entities to ensure members served by multiple programs receive the care and support necessary. The MCO must develop processes and procedures and designate points of contact for collaboration with other entities that serve members, including: Programs funded by the Division of Behavioral Health; Programs funded by the DCFS that support the safety, permanency, and well-being of children in the care and custody of the state; The Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities; The Nebraska Department of Education Early Development Network; Community agencies including, but not limited to, the Area Agencies on Aging and League of Human Dignity Waiver Offices; The Office of Probation; and Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management (p. 32, Nebraska 2017 Medicaid Managed Care Quality Strategy).

[107] The Heritage Health program was designed to simplify the delivery model for Medicaid recipients, by integrating physical health benefits and behavioral health benefits into a single health plan. Being that mental illness and SUDs often co-occur with chronic conditions such as heart disease, cancer, and diabetes, having one health plan responsible for the full range of services for a recipient encourages investment in more cost-effective services to better address the health care needs of the whole person. This integration will allow important information to become available to the care management team, allowing health care managers to identify individuals who may be at risk and facilitate earlier intervention (p. 4). Similar to the Heritage Health program, the dental managed care program includes important initiatives aimed at improving care coordination, as well as access to dental care for Medicaid eligible individuals. The contracted dental benefits program manager (DBPM) will be responsible for establishing a Dental Home program that strengthens the provider-patient relationship, encourages the utilization of preventative services, and promotes positive patient education (p. 4). The mission of the Behavioral Health Integration Advisory Committee is to ensure the successful integration of BH services resulting in a seamless transition for providers and members and improved health outcomes for BH recipients. Core functions: 1) Provide a platform for BH providers and advocates to address

integration-related recommendations, questions, and concerns directly with Heritage Health MCOs and state program administrators. 2) Identify significant BH integration challenges and recommend timely solutions. 3) Identify areas of opportunity and concern in regards to transition of BH services from the current stand-alone program to Heritage Health integrated delivery systems. Issues addressed may include: a) care continuity, b) data transition, and c) credentialing. 4) Advise Heritage Health MCO representatives and state program administrators on best practices for the ongoing integration of behavioral health services (p. 5-6). As BH services are added to the physical health delivery system, goals for all members include decreased reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment. MLTC also anticipates that integrated physical and behavioral health managed care will achieve the following outcomes: Improve health outcomes; Enhance integration of services and quality of care; Put emphasis on person-centered care, including enhanced preventive and care management services (focusing on the early identification of members who require active care management); Reduce rate of costly and avoidable care (p. 6-7). MLTC anticipates the implementation of a Dental PAHP and the selection of a DBPM will advance MLTC's oral health goals, which include: Improved coordination of care (p. 7). The MCO must assess each member for SHCN ("Special Health Care Needs") within 90 calendar days of enrollment. The assessments must be completed by appropriate health care professionals. Assessments that determine a course of treatment or regular care monitoring, as appropriate, must result in a referral for care management (p. 9). Individualized treatment plans resulting from SHCN ("Special Health Care Needs") assessments must be: developed by the member's PCP, with member participation, and in consultation with any specialists caring for the member; approved by the MCO in a timely manner, as defined and required by the MCO; and compliant with applicable quality assurance (QA) and UM standards (p. 10). As BH services are added to the physical health delivery system, goals for all members include: Decreased reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. MLTC also anticipates that integrated physical and BH managed care will achieve the following outcomes: Improved health outcomes; Enhanced integration of services and quality of care; Emphasis on person-centered care, including enhanced preventive and care management services; Reduced rate of costly and avoidable care' and Improved financially sustainable system (p. 33-34). Mental illness and substance use disorders often co-occur with chronic conditions such as heart disease, cancer, and diabetes. Having one health plan responsible for the full range of services for a recipient encourages investment in more cost-effective services to better address the health care needs of the whole person. Integration of physical and behavioral health services supports better communication among PCPs and BH providers, more opportunities for preventive care, and more consistent, all-inclusive coverage for individuals. BH required MCO reporting includes BH PMs that are in the HEDIS, CHIPRA and Adult Medicaid Core measure sets. MLTC requires MCOs to conduct at least one BH- focused PIP annually (p. 38). There are numerous benefits of an integrated MMC model: Heritage Health is a person-centered approach to administering the Medicaid benefits of members; Enhanced care management program in which early identification is key. Once a member is identified for care management, the goal is to prevent costly emergency department visits or hospital readmissions; Improved BH integration system in which one health plan will be responsible for all physical and behavioral health of the member. The goal is to encourage more cost-effective services to better address the complex health care needs of the member; The MCOs and DBPM will report on national quality measures such as HEDIS, CHIPRA and Adult Core Measures. The quality measures will used to set benchmarks for the MCOs/DBPM and implement quality improvement programs; The MCOs and DBPM will be required to have a robust provider network that contains primary care physicians, mental health and substance providers, FQHCs and RHCs, and a vast array of specialists; The goal of the integrated model is to implement a patient-centered approach to ensure that all members' health care needs are addressed. Patient-centered integrated care provides the member and his/her family with comprehensive and coordinated health care from all of the member's providers including PCPs and specialists (p. 39). Managed Dental Care. In the new managed care system, dental providers contract with the DBPM ("Dental Benefits Program Manager") as part of its network, and the DBPM handles claims payment and prior authorizations and works with providers and Medicaid clients to coordinate members' dental care. The DBPM program includes important initiatives aimed at improving care coordination and access to dental care for Medicaid eligible individuals. The contracted DBPM will be responsible for establishing a Dental Home program that strengthens the provider-patient relationship, encourages the utilization of preventative services, and promotes positive patient education (p. 39, Nebraska 2017 Medicaid Managed Care Quality Strategy).

[108] MLTC anticipates the implementation of a Dental PAHP and the selection of a DBPM will advance MLTC's oral health goals, which include… Outreach and education to promote dental health …Increased personal responsibility and self-management (p. 7, Nebraska 2017 Medicaid Managed Care Quality Strategy).

[109] Assessment – National Performance Measures The MCOs and DBPM must report specific PMs, as listed in Table 1: National Performance Measures Identified in the Heritage Health Request for Proposals, and Table 2: DBPM Performance Measures. Measures include national, standardized measures drawn from HEDIS, Adult Core and the Child Core measure sets. MLTC and/or CMS may update performance targets, including choosing additional PMs or removing PMs from the list of requirements, at any time during the contract period. Performance measurement is a key tool that MLTC uses to monitor the MMC program and to continue to improve quality of care over time. The reporting of PMs allows MLTC to understand the quality of care currently being delivered to Nebraska's Medicaid recipients and to trend performance from year to year. PMs include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®2) measures, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Measures required by CMS, CAHPS® measures, the Affordable Care Act (ACA) Adult Quality Measures as defined by CMS (Section 2701 of the ACA), and any other measures as determined by MLTC. The Heritage Health measure set requires MCOs to collect and report measures that include the following areas of care: Screening and preventive care (e.g., cervical cancer screening, childhood immunizations), Chronic care (e.g., asthma and diabetes management), Maternity care (e.g., prenatal and postpartum visits), Access, availability and timeliness of care (e.g., access to primary care well-child visits), Utilization (e.g., emergency department utilization, chronic care admissions), and Satisfaction and experience of care (e.g., CAHPS: satisfaction with physician and health plan) (p. 10, Nebraska 2017 Medicaid Managed Care Quality Strategy).

[110] Case management quality reporting will include data related to outcomes for clients with limited English proficiency and diverse cultural and ethnic backgrounds. The state expects the MCOs and PAHPs to use the information to promote delivery of services in a culturally competent manner, and to reduce racial and ethnic health care disparities for enrollees (p. 8). MLTC has specific Cultural Competency Access standards, which include client access to more than one (1) primary care physician (PCP) that is multi-lingual and culturally diverse. MCOs and the DBPM must have a searchable database that includes network providers and facilities with information regarding race/ethnicity and languages. MCOs assess the cultural, ethnic, racial, and linguistic composition of their networks against the needs and preferences of enrollees and include provider search options for language spoken and ethnicity. (p. 9). The MCO/DBPM must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters in accordance with 42 CFR 438.206(c)(2). The MCO/DBPM must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired. The MCO/DBPM must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities (p. 18). When establishing and maintaining the network, the MCO/DBPM must consider: Members with special health care needs, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities (p. 18). MCOs cannot discriminate against MCO members based on their health history or status, need for health care services, or adverse change in health status; or on the basis of age, religious belief, gender, sexual orientation, ethnicity, or language needs. This applies to enrollment, re-enrollment, or disenrollment from the MCO (p. 22, Nebraska 2017 Medicaid Managed Care Quality Strategy).

[111] Value-Based Purchasing Initiatives The Heritage Health Program has been designed to promote greater collaboration between MCOs and providers by encouraging more sophisticated strategies for purchasing health care services. Value-based purchasing (VBP) requirements promote added value for members and providers by aligning the financial goals of the MCO and the provider. MLTC defines value-based contracts as payment and contractual arrangements between the MCOs and providers that include: Accountability for improvements in health outcomes, care quality, or cost efficiency; and Payment methodologies that align providers' financial and contractual incentives with those of the MCO. The state requires MCOs to enter into value-

based contracts with a growing portion of its contracted providers over the five-year contract period, and with at least 50% of its providers by the fifth year of the contract. It is anticipated that this movement toward VBP will facilitate progress toward the Quality Strategy goals of enhanced quality of care, improved outcomes, and reduced costly and avoidable care (p.35, Nebraska 2017 Medicaid Managed Care Quality Strategy).

[112] Objective 1.1 - Ensure that annual preventative care measure rates are equal to or higher than the national average of Medicaid managed care health plan rates (p. 6). Network Adequacy Standards. PCPs (adult and pediatric) - Two (2) within forty (40) minutes or fifteen (15) miles (p. 54). Availability of Service Standards. Non-symptomatic (i.e., preventive care) office visits shall be available from the member's PCP or another provider within forty-five (45) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations; Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the member's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs or symptoms not requiring immediate attention; Urgent, symptomatic office visits shall be available from the member's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs or symptoms that require immediate attention but are not life-threatening and don't meet the definition of Emergency Medical Condition (pp. 54-55, New Hampshire 2018 Medicaid Managed Care Quality Strategy).

[113] C. Managed Care Quality Program Goals and Objectives Goal 1- Assure the quality and appropriateness of care delivered to the NH Medicaid population enrolled in managed care. Objective 1.1 – Ensure that annual preventive care measure rates are equal to or higher than the national average of Medicaid managed care health plan rates. The Medicaid Quality Program collects annual data on preventive care from each MCO. These indicators are a blend of clinical process and outcome measures related to the topic of prevention. The measure set is informed by the NCQA Quality Health Plan Ratings and includes measures from HEDIS as well as the CMS Adult and Child Core Sets. Each measure is compared to NCQA Quality Compass national average of Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national average. Result are annually presented to internal stakeholders, the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov (p. 6-7, New Hampshire 2018 Medicaid Managed Care Quality Strategy).

[114] The State currently obtains race (multiple categories), Hispanic ethnicity, and primary language spoken, during its eligibility and NH Medicaid enrollment process. This information in addition to disability eligibility status is shared with the MCOs as a part of daily eligibility data feeds through the 834 file. Currently the MCOs are required to implement Cultural Competency Plans that assure that providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. To compliment the activities associated with the Cultural Competency Plans, DHHS is working to formalize the inclusion of reducing health disparities as a unique activity to be administered by the MCO's QAPI programs (p. 15, New Hampshire 2018 Medicaid Managed Care Quality Strategy).

[115] Goal 1: To improve timely, appropriate access to primary, preventive, and long-term services and supports for adults and children (p. 7). Geographic Access. The following lists guidelines for urban geographic access for the DMAHS population. 1) Beneficiary children who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Pediatrics or 2 CNPs/CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Pediatrics or 1 CNP or 1 CNS. 2) Beneficiary adults who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Internal Medicine or 2 CNPs or 2 CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Internal Medicine or 1 CNP or 1 CNS. 3) Beneficiaries who reside within 6 miles of 2 providers of general dentistry services; within 2 miles of 1 provider of general dentistry services (p. 28). Access Standards. 1) 90% of the enrollees must be within 6 miles of 2 PCPs and 2 PCDs in an urban setting; 2) 85% of the enrollees must be within 15 miles of 2 PCPs and 2 PCDs in a non-urban setting; 3) Covering physicians must be within 15 miles in urban areas and 25 miles in non-urban areas (p. 28). Time Travel Standards. The contractor shall adhere to the 30-minute standard, i.e., enrollees will not live more than 30 minutes away from their PCPs, PCDs or CNPs/CNSs. The following guidelines shall be used in determining travel time: 1) Normal conditions/primary roads - 20 miles; 2) Rural or mountainous areas/secondary routes - 20 miles; 3) Flat areas or areas connected by interstate highways - 25 miles; 4) Metropolitan areas such as Newark, Camden, Trenton, Paterson, Jersey City - 30 minutes travel time by public transportation or no more than 6 miles from PCP; 5) Other medical service providers must also be geographically accessible to the enrollees; 6) Exception: Social Security's Supplemental Insurance program (SSI) or New Jersey Care- Aged, Blind or Disabled (ABD) enrollees and clients of DDD may choose to see network providers outside of their county of residence (pp. 28-29). Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Physicians. 1) A physician must demonstrate increased office hours and must maintain (and be present for) a minimum of 20 hours per week in each county; 2) In private practice settings where a physician employs or directly works with nurse practitioners who can provide patient care within the scope of their practices, the capacity may be increased to 1 PCP FTE to 3500 members. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP; 3) In private practice settings where a primary care physician employs or is assisted by other licensed, but non-participating physicians, the capacity may be increased to 1 PCP FTE to 3500 members; 4) In clinic practice settings where a PCP provides direct personal supervision of medical residents with a New Jersey license to practice medicine in good standing with State Board of Medical Examiners, the capacity may be increased with the following ratios: 1 PCP to 2000 members; 1 licensed medical resident per 1100 members. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP; 5) Each provider (physician or nurse practitioner) must provide a minimum of 15 minutes of patient care per patient encounter and be able to provide four visits per year per member (Appendix E, p. 103). Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Dentists. 1) A PCD must provide a minimum of 20 hours per week per county; 2) In clinic practice settings where a PCD provides direct personal supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing and also dental students, the capacity may be increased with the following ratios: 1 PCD to 2000 members per contractor; 1 dental resident per 1000 members per contractor; 1 FTE dental student per 300 members per contractor. The PCD shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD; 3) In private practice settings where a PCD employs or is assisted by other licensed, but non-participating dentists, the capacity may be increased to 1 PCD FTE to 3500 members; 4) In private practice settings where a PCD employs dental hygienists or is assisted by dental assistants, the capacity may be increased to 1 PCD to 3500 members. The PCD shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD; 5) Each PCD shall provide a minimum of 15 minutes of patient care per patient encounter; 6) The contractor shall submit for prior approval by the DMAHS a detailed description of the PCD's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, 24 hour access system; 7) The contractor shall provide information on total patient load across all plans, private patients, Medicaid fee-for-service patients, other; 8) The contractor shall adhere to the access/appointment availability standards required in the contractor's contract with the Department (p. 104, Appendix E, New Jersey 2014 Medicaid Managed Care Quality Strategy).

[116] Guiding Values or Principles: Behavioral health treatment services, historically provided on a fee for service basis, will be integrated into managed care, providing opportunities to enhance coordination of primary and behavioral healthcare (p. 8). Medical Home: Primary care providers must be identified for participation in the demonstration project that provides care to enrollees with a chronic health condition and/or behavioral health condition using a medical home model. Focus is encouraged to the development of Medical Homes for the developmentally disabled and frail elderly... the services offered to enrollees participating in the medical home demonstration project include: patient care coordination through multi-disciplinary teams; individualized customized care plans that promote self-management; patient/family education for enrollees with chronic diseases; home-based services; telephonic communications; group care; oral health examinations; and culturally and linguistically appropriate care (p. 86). Annual Care/Case Management Audits: The records are evaluated for timely outreach, including early identification of special needs populations...; completion of an initial health screening, designed to quickly identify members

who are in need of care management...; a needs assessment and care plan if appropriate; different levels of care management; preventative services, like BMI percentile/values care of lead-burdened children; adherence to lead screening protocols; embellishment of appropriate linkages within and outside the MCO; continuity of care; coordination of services; and discharge planning following hospitalization (p. 34). Care Management Tool: With the assistance from CHCS, the State has developed a case management tool that allows for early identification of members in need of care management services. All new members... will be screened using an approved Initial Health Screening tool to quickly identify their immediate physical and/or behavioral health care needs as well as the need for more extensive screening. Any member identifies by a health care professional as having potential care management needs... will receive a more detailed comprehensive needs assessment and an ongoing care coordination (sic) and management as appropriate (p. 85, New Jersey 2014 Medicaid Managed Care Quality Strategy).

[117] With these capabilities in place the NJ Medicaid Enterprise will be able to…promote member engagement in their health care (p. 79). Guiding values or principles…members are supported in taking responsibility for their own health and health care, including the opportunity to self-direct care where appropriate (p. 7). The services offered to enrollees participating in the Medical Home demonstration project include: individualized customized care plans that promote self-management (p. 86, New Jersey 2014 Medicaid Managed Care Quality Strategy).

[118] Displayed in Table 1 (Dashboard Quality Strategy Objectives) are performance data on priority areas for measurement for Year 2012 and corresponding targets objectives for the next five years. The various improvement strategies are anticipated to sustain progress towards the achievement of these target goals. Quality Strategy Objectives include children and adolescent's access to primary care, adult's access to preventive care, childhood immunization, BMI assessment for children and adolescents, adult BMI assessment, HbA1c testing and control, and controlling blood pressure (p. 81, New Jersey 2014 Medicaid Managed Care Quality Strategy).

[119] Guiding Values or Principles: Cultural sensitivity is an essential element in providing quality services to a diverse population and decreasing disparities (p. 8). Each MCO is provided with the race/ethnicity and the primary language spoken of their enrollees…The contract requires MCOs to have Member Services staff that includes individuals who speak English, Spanish, and any other language that is spoken as a primary language by a population that exceeds five (5) percent of the MCO's enrollees or two hundred (200) enrollees in the contractor's plan, whichever is greater. Additionally, the MCO provider networks must include providers who can accommodate the different languages of the enrollees. If the language and/or cultural needs of an enrollee are known to the MCO and the MCO has not received information on the enrollee's selected Primary Care Physician (PCP), the MCO is expected to assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee or have the ability to interpret in the provision of health care services and related activities during the enrollee's office visits or contacts (p. 16). Community Advisory Committee. Contractor shall implement and maintain community linkages through the formation of a Community Advisory Committee (CAC) with demonstrated participation of consumers…, community advocates, and traditional and safety net providers. The contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who speak a primary language other than English and cultural competency… Contractor shall assess the linguistic and cultural needs of its enrollees who speak a primary language other than English. The findings of the assessment shall be submitted to MAHS in the form of a plan…at the end of year one of the contract. In the plan, the contractor will summarize the methodology, findings, and outline the proposed services to be implemented, the timeline for implementation with milestones, and the responsible individual. The contractor shall ensure implementation of the plan within six months after the beginning of year two of the contract…The contractor shall address the special health care needs of all enrollees. The contractor shall incorporate in its policies and procedures the values of (1) honoring enrollees' beliefs, (2) being sensitive to cultural diversity, and (3) fostering respect for enrollees' cultural backgrounds…The contractor shall be responsible for ensuring that its network providers do not intentionally segregate DMAHS enrollees (p. 17). Each HMO will participate in the State's efforts to promote the delivery of service in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds by: ensuring that the HMO staff have training and experience needed to provide effective services to members with communication - affecting conditions and include staff who speak English, Spanish, and any other language which is spoken as a primary language by the population that exceeds five (5) percent of the contractor's NJ FamilyCare members or two hundred (200) members in the contractor's plan, whichever is greater. Contractor's shall participate in the DHS Cultural and Linguistic Competency Task Force and provide culturally competent services that address the relationship between culture, language and health care outcomes. –The HMO is required to have available 24-hour interpreter services for all members speaking non-English languages. –The HMO is required to have 24-hour access to interpreter services for all members needing TDD/TT services. –The HMO will encourage and foster cultural competency in its employees (p. 105-106, New Jersey 2014 Medicaid Managed Care Quality Strategy).

[120] NJ Accountable Care Organization Demonstration Project. Shared savings payment arrangement through the ACO to achieve ACO-related goals. The legislation stipulated that qualified ACOs must seek and be certified by the New Jersey Department of Human Services. Under the law, New Jersey nonprofit corporations that wish to form a community-based ACO must demonstrate the support of all general hospitals, no fewer than 75% of qualified primary care providers, and at least four qualified behavioral health providers located in the designated area served by the ACO (p. 87, New Jersey 2014 Medicaid Managed Care Quality Strategy).

[121] Access Standards: Member caseload of any PCP should not exceed two-thousand (2,000) (p. 10). Distance Requirements for PCPs (including internal medicine, general practice, and family practice types), and pharmacies: Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles; Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles; Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles (p. 10). Timeliness requirements: No more than thirty (30) Calendar Days, for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care; No more than sixty (60) Calendar Days, for routine, asymptomatic member- initiated dental appointments; No more than fourteen (14) calendar Days for routine, symptomatic member- initiated, outpatient appointments for non-urgent primary medical, behavioral health and dental care; Within twenty four (24) hours for Primary medical, behavioral health and dental care outpatient appointments for urgent conditions (p. 10 New Mexico 2017 Medicaid Managed Care Quality Strategy).

[122] Centennial Care objectives include: 4. Develop collaborative strategies and initiatives with state agencies and other external partners (p. 13). The key traits of high-quality, high value healthcare include: Member-Centered to encompass respect for members' values, preferences, and expressed needs; coordination and integration of care; information, communication and involvement of family and friends (p. 18, New Mexico 2017 Medicaid Managed Care Quality Strategy).

[123] Care Coordination Standards: A comprehensive care coordination model fosters the goal of ensuring that Medicaid recipients receive the right care, at the right time, and in the right place. MCOs establish levels of care coordination for members based on an assessment to determine the level of support that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to reassess the individual and, as appropriate, make the corresponding changes in their care coordination level of support. HSD/MAD requires the MCOs to conduct a standardized health risk assessment (HRA) on each member to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a Comprehensive Care Plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members assigned to coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs are required to routinely monitor claims and utilization data for all members (including members who are not assigned to care coordination levels 2 or 3) to identify changes in health status and high-risk members in need of a higher level of care coordination. Additional components of care coordination includes: Assessing each member's physical, behavioral, functional and psychosocial needs; Identifying the specific medical, behavioral, LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet the member's needs; Assessing members for LTSS. This applies to members of all ages who have functional limitations and/or chronic illnesses. The primary purpose is to support the ability of the beneficiary to receive services in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or institutional setting; Identifying members with special health care needs. The state defines members with special health care needs as those who have or are at increased risk for a disease, defect or medical condition

that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally; Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare (p. 8-9). Centennial Care objectives include: 4. Develop collaborative strategies and initiatives with state agencies and other external partners (p. 13, New Mexico 2017 Medicaid Managed Care Quality Strategy).

[124] Guiding principles …Increasing personal responsibility; …Encouraging active engagement of members in their health care (p. 4). Health Disparities… Resources include but are not limited to:… Member rewards program to encourage member engagement with preventive services and follow up care by incentivizing beneficiaries to pursue healthy behaviors (p. 12). The key traits of high-quality, high value healthcare include… Member-Centered to encompass respect for members' values, preferences, and expressed needs; coordination and integration of care; information, communication and involvement of family and friends (p. 18, New Mexico 2017 Medicaid Managed Care Quality Strategy).

[125] Performance Improvement Projects (PIPs) The MCO contract continues to direct the MCOs to, at a minimum, implement the following PIPs: One (1) on Services to Children and; One (1) on Diabetes Prevention and Management (p. 22-24). Child and Adult Core Set Quality Measures HSD/MAD reports on CMS determined Child Core Set and Adult Core Set Quality Measures through the Medicaid and CHIP Program (MACPro) systems data entry portal. The CMS defined Core Set of Quality Measures provides New Mexico with a nationally recognized set of core quality measures to track performance and identify areas needing improvement. Reporting on these performance measures will assist HSD/MAD to further enhance the quality of health care for both Children and Adults within the States Medicaid program (p. 24, New Mexico 2017 Medicaid Managed Care Quality Strategy).

[126] All health care providers rendering services to Medicaid beneficiaries must render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief or source of payment (p. 11). Health Disparities: Resources include... Requiring the MCO to develop a Cultural Competence and Sensitivity Plan to ensure that covered services provided to members are culturally competent and include provisions for monitoring and evaluating disparities in membership, especially as related to Native Americans (p. 12, New Mexico 2017 Medicaid Managed Care Quality Strategy).

[127] CMS requirement CFR §438.340(b)(10). HSD conducts internal quality review activities such as: Monitoring MCO continued expansion of the PCMH model by engaging PCMH providers to conduct care coordination activities for their attributed members through value-based purchasing (VBP) arrangements. Centennial Care 2.0 seeks to expand of this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model). Monitoring activities shall occur through MCO reporting to HSD and verification of VBP initiatives (p. 28, New Mexico 2017 Medicaid Managed Care Quality Strategy).

[128] Ongoing Focused Reviews. Appointment Availability Standards. MCOs are required to conduct access and appointment availability studies and to follow-up when they identify providers who are not in compliance with 24-hour coverage and appointment availability requirements (p. 24). Access to Care: Access to care impacts members' overall physical, social, and mental health status, and quality of life. It also affects the prevention of disease, preventable death, and promotes detection and treatment of health conditions. Disparities in access to care affect both individuals and the whole society. Medicaid health plans had high rates of children and adolescents' accessing primary care when compared with other types of insurance in 2012. CHP health plans exceeded all types of insurance in children and adolescents' access to care. NYS hopes to continue to increase the percentage of adult Medicaid members who have a regular health care provider. MMC plans are being encouraged to increase the use of patient reminders and recall systems to maintain regular preventive care visits, and to educate parents about the diseases that can be prevented and detected in the early stages with regular visits to a primary care provider (p. 36, New York 2014 Medicaid Managed Care Quality Strategy).

[129] The MRT also recommended integration of specialty behavioral health services into mainstream Medicaid managed care plans... (p. 3). Program Initiative Objectives: Increase provider implementation of evidence-based practices that integrate behavioral and physical health services, including addiction pharmacotherapy; Improve care coordination for individuals with complex behavioral and physical health needs (p. 6). Through greater case management, health homes, patent centered care, and the performing provider practice partnerships in the DSRIP program, NYS DOH believes patient satisfaction with MMC will continue to increase across all measures (p. 36). In 2015, CMS approved a waiver to the Partnership Plan allowing for the integration of behavioral health services into managed care Similarly, OASAS, OMH, and DOH are working to improve care coordination for individuals with mental illness, SUDs, or both, across primary and behavioral health care settings... Care managers and care management teams will help ensure that recipients actively engage with their PCPs, behavioral health providers, and social supports, including those in HCBS settings, to complete appropriate treatment, with the ultimate aim of achieving lifelong recovery and wellness (p. 37, New York 2014 Medicaid Managed Care Quality Strategy).

[130] Specific objectives of managed care for people with intellectual and developmental disabilities relate to:… Making the system more person centered --supports and services that match each person's unique identified interests and needs, including opportunities for self-direction (p. 7). The OPWDD leadership team is advised by the Commissioner's DD Advisory Council established by NYS Mental Hygiene Law (13.05) and comprised of self-advocates, family members, provider representatives, and other stakeholders, and an array of other internal and external stakeholders that represent various constituencies, including the OPWDD Provider Associations; the Self Advocacy Association of New York State; the Statewide Committee for Family Support Services; and many others (p. 18). Membership on MCO/HARP Subcommittees. MCOs are required to maintain an active behavioral health QM subcommittee which must include, in an advisory capacity, members, family members, peer specialists, and provider representatives (p. 28). MMC plans are being encouraged to increase the use of patient reminders and recall systems to maintain regular preventive care visits, and to educate parents about the diseases that can be prevented and detected in the early stages with regular visits to a primary care provider (p. 36). OPWDD System Reform Measures…Self-Direction…a. Provision of education on self-direction to waiver participants b. Participants are able to make an informed choice on whether to self-direct their supports and services c. Participants who self-direct their supports and services do so with employer authority and/or budget authority (p. 61, New York 2014 Medicaid Managed Care Quality Strategy).

[131] In addition to national measures obtained from these sources, NYS has expanded its evaluation of managed care objectives to include state-specific measures. The QARR quality measurement set and other data sources used for assessment of the managed care delivery system in NYS are described below. a) QARR Measurement Set QARR focuses on health outcome and process measures, and includes clinical data relating to prenatal care, preventive care, acute and chronic illnesses, and mental health and substance abuse for children and adults in Medicaid/CHIP. QARR is submitted annually, in June of the year following the measurement year and published in web-based formats (p. 9). b) Performance Improvement Projects Currently, health plans are collaborating on PIPs targeting prevention of chronic diseases. Smoking cessation work continues in the 2015-2016 PIP, with a concentration on increasing the utilization of smoking cessation benefits (p. 15, New York 2014 Medicaid Managed Care Quality Strategy).

[132] The state complies... by detailing... procedures that... 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 (p. 8). Enrollee/advocate board members and /or the advisory body will provide the plan with information regarding enrollee satisfaction and the DISCO's responsiveness to cultural considerations of the enrollee community (p. 27, New York 2014 Medicaid Managed Care Quality Strategy).

[133] Goal 1: Improve the health and wellness of Nevada's Medicaid and Nevada Check Up population by increasing the use of preventative services; Objectives 1.1a-d: Increase access to children and adolescents access to primary care physicians; Objectives 1.2-1.3: Increase well-child visits; Objective 1.6: Increase annual dental visits for children; Objective 1.8: Increase adolescent well child visits (p. 1-11 – 1-12). Now Clinic was approved, which will provide telemedicine services to initiate engagement within the Medicaid population and encourage PCP visits for routine care (p. 6-2, Nevada 2016 Medicaid Managed Care Quality Strategy).

[134] Objective 5.4-5.5: Increase follow up after hospitalization for mental illness at 7 and 30 days (p. 1-13). For other CSHCN recipients, an assessment and treatment plan should be developed in conjunction with the recipient's primary care provider (PCP), with the recipient's participation and in consultation with specialists (p. 2-3, Nevada 2016 Managed Care Quality Strategy).

[135] HPV Postcards were administered to members who started the HPV series of shots but had not completed the series. The outreach initiative showed an increase of 5 percentage points in less than one year (p. 6-2). Taking Care of Baby and Me program provided monetary incentives for first trimester and ongoing prenatal care visits, in addition to automated outreach calls (p. 6-2). Major goals for the program include… Increase participation in self-directed option (individuals control their own services and supports) (p. 6-8). Nevada's MIPCD program consists of three major program components…Nesting incentives in the diabetes disease management programs conducted by Nevada's Medicaid MCOs. MCO enrollees with diabetes will be incentivized to receive evidence based preventive health services known to be effective in improved management of diabetes and covered under the Nevada Medicaid state plan (p. 6-8, Nevada 2016 Medicaid Managed Care Quality Strategy).

[136] Goal 6: Increase reporting on CMS quality measures. Objectives 6.1: Increase the number of CMS adult core measures reported to the Medicaid and CHIP Program (MACPro) System. Objective 6.2: Increase the number of CMS child core measures reported to MACPro (p. 1-13 – 1-14). Performance Improvement Projects (PIPs) Table 2-2 lists the Nevada Medicaid and Nevada Check Up PIPs planned for 2016 – 2017. Performance Improvement Project(s) – Reducing Behavioral Health-Related Hospital Readmissions Within 30 Days of Discharge; Improving Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (p. 2-10, Nevada 2016 Medicaid Managed Care Quality Strategy).

[137] Objective 3.1: Ensure that health plans develop, submit for review, and annually revise cultural competency plans; Objective 3.3: Ensure that each MCO submits an annual evaluation of their cultural competency program to DHCFP... (p. 1-13). The DHCFP reviews the MCOs' deliverables throughout the year to evaluate their compliance with the contract in the following areas: … Cultural competency (p. 1-16). Procedures for Race, Ethnicity, and Primary Language Data Collection and Communication: DHCFP requires the MCOs to participate in Nevada's efforts to promote the delivery of service in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The DHCFP continually monitors how race, ethnicity, and the primary language of enrollees are collected, coded, and entered into the system to ensure that this information is compliant with [HIPAA]… The DHCFP provides information on race, ethnicity, and primary language spoken to the health plans as part of the member eligibility file. Health plans are required to use the data in their efforts to identify and overcome racial and ethnic disparities in health care. The MCOs, in cooperation with the DHCFP, are required to develop and implement a Cultural Competency Plan (CCP) that encourages delivery of services in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds... As part of their cultural competency initiatives, the MCOs examine disparities through analysis of their HEDIS measures and PIPs (p. 2-1). DHCFP requires the MCOs to participate in Nevada's efforts to promote the delivery of service in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds (p. 6-5). As part of their cultural competency initiatives, the MCOs examine disparities through analysis of their performance measures and PIPs. The MCOs also examine indicators used for assessing achievement of the Quality Strategy goals and objectives. The MCOs stratify PIP and performance measure data by race/ethnicity to identify disparities and opportunities to overcome barriers that impede improvement. Based on their findings, the MCOs incorporate specific interventions for race and ethnicity to improve indicator rates. Furthermore, the MCOs are required to document stratification findings and planned interventions to reduce health care disparities in their annual cultural competency plan evaluation and Quality Strategy evaluation. Both of these documents are submitted to the DHCFP annually for review and approval. As part of the collaborative effort by the DHCFP and MCOs to reduce disparities in health care and improve access to care for Native Americans, the DHCFP hosted a meeting at the beginning of SFY 2014–2015, wherein a member of the Reno Sparks Tribal Health Center presented information about the barriers that exist for Native Americans in accessing services coordinated by the MCOs. The DHCFP, MCOs, and the tribal health center committed to having ongoing discussions about how to build awareness and reduce barriers to care for Native Americans and improve collaboration between Nevada Medicaid and tribal health care services. The MCOs are also required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is not English (p. 6-6, Nevada 2016 Medicaid Managed Care Quality Strategy).

[138] MCO-Specific Quality Initiatives. Health Plan of Nevada (HPN). Pay for Performance program was conceptualized and contracts were issued. The program will incentivize high-volume primary care providers' (PCPs') offices to increase HEDIS rates for members empaneled with the PCP (p. 6-1, Nevada 2016 Medicaid Managed Care Quality Strategy).

[139] ODM monitors the adequacy of provider networks through examining survey, utilization, and complaints data. Corrective action is taken when necessary. Beginning in January 2019, ODM will quarterly assess MCP compliance with time and distance standards using internal mapping and analytics software (p. 15). Standards for timely access to care and services are set forth in OAC rules and include the following: immediate treatment and triage of members with emergency care needs when they first come to their primary care provider; treatment of members with persistent symptoms before the end of the following working day after their initial contact with their primary care provider; meeting requests for routine care within six weeks of the request (p. 15). Comprehensive Primary Care Support. In January of 2018, ODM launched a quality improvement project with MCPs and CPCs designed to improve managed care plan support of comprehensive primary care practices in order to increase the percentage of high-risk patients receiving preventive care. Although the project is still in its infancy, primary strategies by the MCPs implemented to date have included building trusting relationships with the CPCs, assessing the accuracy of claims data used to determine patient attribution to a CPC practice, and outreach to patients to determine barriers to utilizing primary care (p. 59, Ohio 2018 Draft Medicaid Managed Care Quality Strategy).

[140] Our goal is to improve population health outcomes by having all Medicaid recipients participate in the redesigned health care delivery system, increasing preventative screens and appropriate care, addressing priority population health issues such as decreasing racial disparities in preterm birth and infant mortality rates, integrating behavioral and physical health care, optimally managing chronic conditions, and addressing social determinants of health as appropriate (p. i). Current health equity efforts are focused on... capitalizing on MCP partnerships with community-based organizations to address additional contributors to infant mortality and reducing disparities in hypertension control between African American and Caucasian Medicaid members in control of hypertension (p. 12). The MCP will assign care managers and use a multidisciplinary team when a member's physical, psychosocial, and/or behavioral conditions would benefit from a range of disciplines with different, but complementary skills, knowledge and experience working together to deliver an integrated, comprehensive approach to care management (p. 21, Ohio 2018 Draft Medicaid Managed Care Quality Strategy).

[141] Our goal is to improve population health outcomes by having all Medicaid recipients participate in the redesigned health care delivery system, increasing preventative screens and appropriate care, addressing priority population health issues such as decreasing racial disparities in preterm birth and infant mortality rates, integrating behavioral and physical health care, optimally managing chronic conditions, and addressing social determinants of health as appropriate (p. 1). ODM's quality strategy focuses on incorporating best practices and transforming its systems in an effort to improve quality, experience, and cost outcomes. This includes using continuous quality improvement methods such as... the comprehensive primary care model for coordinating care; redesigning behavioral to better coordinate across payers and support parity (p. 9). The MCP will assign care managers and use a multidisciplinary team when a member's physical, psychosocial, and/or behavioral conditions would benefit from a range of disciplines with different, but complementary skills, knowledge and experience working together to deliver an integrated, comprehensive approach to care management (p. 21). Behavioral health redesign: transition from BH carve-out to "carve-in" (p. 50). In July 2018, behavioral health treatment services, historically provided on a fee for service basis, will be integrated into managed care, providing opportunities to enhance coordination of primary and behavioral healthcare (p. 73). Ohio's

Comprehensive Primary Care (CPC) Program: Ohio CPC is an investment in primary care infrastructure intended to support improved population health outcomes. CPC is a patient-centered medical home program, which is a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs (p. 51). In 2016, ODM shifted focus from care management to population health management strategies and emphasized better integration of clinical partners' efforts to improve health outcomes. For the 2018 update, ODM reinforced population health management as the primary driver of resource allocation, infrastructure and processes to improve health outcomes. Components of the population health program are as follows: Identification, Prioritization, Programming; & Continuous quality improvement (p. 54, Ohio 2018 Draft Medicaid Managed Care Quality Strategy).

[142] Managed Care Plans (MCP): ODM's quality management strategy is informed through… MCP Family Advisory council input (p. 6). Using a person-centered process and the results of the most recent assessment, the MCP will develop an individualized care plan that includes prioritized, measurable goals, interventions, and desired outcomes. Goals must be developed with and should be agreed to by the member and documented in the care plan (p. 21). The MyCare Ohio approach is centered on the individual and incorporates a care team to effectively coordinate care based on an individual's specific needs. This care team includes: the individual, the individual's family/caregiver, the MyCare Ohio care manager, the waiver service coordinator (if appropriate), the primary care provider, specialists, and other providers as applicable. This model supports the goals of integrating patient and family care preferences, and clear communication, accessible and optimized care (p. 49). Attributes of a high performing care management system include: … and promotion of members' self-care and independence (p. 55). Social determinants of health, such as a safe living environment and neighborhood, stable housing, the availability of transportation, adequate and healthful food, and quality childcare all have an impact on the ability of Medicaid recipients to be actively engaged in their own health and wellbeing and to take ownership of their healthcare (p. 63, Ohio 2018 Draft Medicaid Managed Care Quality Strategy).

[143] Managed Care Program Goals and Objectives. Continuously improving population health and healthcare quality. ODM's quality strategy focuses on incorporating best practices and transforming its systems in an effort to improve quality, experience, and cost outcomes. This includes using continuous quality improvement methods such as process mapping, key driver diagrams, and plan-do-study-act cycles to streamline workflow and remove administrative barriers across the care continuum; assessing and incorporating the voice and the experience of our high-risk communities through community engagement and collaboration; promoting value-based initiatives such as episode-based payment and the comprehensive primary care model for coordinating care; redesigning behavioral health to better coordinate across payers and support parity; redesigning the care management system; and producing actionable and timely data for decision making (p. 9). V. Improvements and Interventions. Transforming ODM's Managed Care Plan Quality Improvement Program. Three components of the MCPs' quality improvement program were revised for a January 1, 2018 effective date: population health management program, MCP quality improvement programs, and incentives to promote MCP performance. Population Health Management In 2016, ODM shifted focus from care management to population health management strategies and emphasized better integration of clinical partners' efforts to improve health outcomes. For the 2018 update, ODM reinforced population health management as the primary driver of resource allocation, infrastructure and processes to improve health outcomes. Components of the population health program are as follows: Identification – Use of assessments, claims, and supplemental data sources to identify clinical cohorts that align with ODM's five population streams (women's health, chronic conditions, behavioral health, and healthy children & adults); Prioritization – Assign a risk level considering clinical conditions, social determinants, geography, etc. for the purpose of targeting interventions and allocating resources based on member's needs; Programming – Comprehensive offering of services tailored to population stream and risk level. Examples include medical homes, disease management, health and wellness programs, enhanced maternal care, care management, community workers, etc.; and Continuous quality improvement – Assessment and improvement of specialized programming for each group identified by the MCP's population health management strategy. Each MCP is required to develop a model of care for ODM review and approval that describes how specialized services and resources are tailored to the MCP's population. This new approach was rolled out in Medicaid Managed Care and MyCare in 2016 and 2017, respectively, and continues to be implemented in 2018 (p.54). MCP Quality Improvement Programs. Improvement Initiatives. ODM requires MCPs to actively participate in both federally-required improvement projects and quality improvement projects reflecting state efforts to improve quality of care and outcomes. The topic choice for ODM required improvement projects is tied to the state quality strategy and focuses on one of the five population health streams (women's health, adults and children with chronic conditions, adults and children with behavioral health needs, healthy children and healthy adults) (p.58). Comprehensive Primary Care Support. In January of 2018, ODM launched a quality improvement project with MCPs and CPCs designed to improve managed care plan support of comprehensive primary care practices in order to increase the percentage of high-risk patients receiving preventive care. Although the project is still in its infancy, primary strategies by the MCPs implemented to date have included building trusting relationships with the CPCs, assessing the accuracy of claims data used to determine patient attribution to a CPC practice, and outreach to patients to determine barriers to utilizing primary care (p. 59). Chronic Condition Interventions. Hypertension Control Improvement Project. In 2017, ODM received permission to align MCPs and MCOPs in the use of quality improvement science-based approaches to impact health outcomes. ODM launched the hypertension improvement project In January 2018. This project became the federally required performance improvement project for the Medicaid Managed Care Plans and the new Quality Improvement project for the MyCare Ohio plans. The effort differs significantly from the MyCare Chronic Condition Improvement Project in that it has an equity focus, utilizes frequent data collection via clinical electronic health records, requires collaboration with participating practices, capitalizes on electronic health record data, and uses quality improvement science tools and methods to more rapidly determine needed adaptions in order to spread successful interventions. The Hypertension Improvement Project is aimed at the Medicaid population of adults with chronic conditions, specifically cardiovascular disease as exhibited by uncontrolled hypertension. This project includes a focus on health disparities, informed by data demonstrating much higher rates of uncontrolled hypertension among African American compared Caucasian patients. To begin closing this disparity, the project SMART aims include improving the control of hypertension by 15% in the overall study population and 20% in the African American population. The effort involves spreading clinical best practices shown to be effective in controlling hypertension and reducing disparities. The project's key drivers and interventions include: accurate blood pressure measurement, timely follow-up for high blood pressure, tailoring of outreach and communication to be culturally appropriate and adherence to a medication treatment algorithm. Partner practice sites were selected in part for strong representation of African American patients (approximately 40% of the total study patient population) (p.62). Gestational Diabetes Mellitus (GDM). The Ohio Department of Health and Ohio Medicaid are partnering to increase the number of women with a history of Gestational Diabetes Mellitus (GDM) who receive recommended screening and education for type 2 diabetes (T2DM). Participating practices test interventions, including the piloting of clinical and patient toolkits that include the following resources: clinical decision algorithms for diagnosing GDM and T2DM; office flow charts for assessing GDM and screening for T2DM; and recommendations for improving care coordination between prenatal and primary care providers. The 29 original Ohio OB-GYN and Maternal Fetal Medicine practices are now focused on sustaining successful processes developed as part of quality improvement interventions to improve rates for: timely screening of pregnant women for gestational diabetes; postpartum visits; and postpartum T2DM screening within recommended timeframes. Currently, 15 Ohio Primary Care Practices are engaged in testing interventions to improve rates for: assessing women for a history of GDM or at risk for T2DM; and improving T2DM screening rates throughout the life course (p. 62-63, Ohio 2018 Draft Medicaid Managed Care Quality Strategy).

[144] Methods for identifying age, race, ethnicity, sex, primary language, and disability status… ODM requires MCPs to use demographic information to promote culturally competent service delivery and to progress toward the goal of reducing health disparities. This includes efforts to ensure that provider networks are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender, and other unique needs of the managed care population... MCPs are contractually obligated to deliver services in a culturally competent manner to all members, including those with Limited English Proficiency (LEP). If a common primary language other than English is identified as being prevalent in the MCP's service area, the MCP is required to translate marketing and member materials and to make oral interpreter services available free of charge. ODM recognizes that some members may have other special communication needs, such as limited reading proficiency, limited health literacy, visual impairment, and hearing impairment. In such cases, MCPs are required to provide assistance to members, maintain a centralized database of special communication needs, and provide related services; MCPs must also share this information with providers. ODM monitors

this requirement as part of the administrative compliance audit (p. 11). MCPs are responsible for promoting the delivery of services in a culturally competent manner, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds. The MCP must comply with the requirements specified in OAC rules and provider agreements for providing assistance to members with LEP and eligible individuals. This includes free translations of marketing and member materials into non-English languages prevalent in the MCP's service area. All MCP subcontractors must also not discriminate in the delivery of services based on the member's race, color, religion, gender, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services. MCPs must inform providers of their obligation to provide oral translation, oral interpretation, and sign language services to the MCP's members. These policies must include: the provider's responsibility to identify those members who may require such assistance; the process the provider is to follow in arranging for such services to be provided; and the specification of whether the MCP or the provider will be financially responsible for the costs of providing these services. Both MCPs and providers are prohibited from holding members liable for the costs of these services. The MCP must record special communication needs (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) when identified by any source and the resulting provision of related services for all its members in a centralized database. This centralized database must be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available. The MCP must share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable. MCPs are required to assign a staff person to coordinate, document, and assess the provision of sign language, oral interpretation, and oral translation services. MCPs are required to use person-centered language in all communications with eligible individuals and members. Person-first language resources are available form national organizations, including the Centers for Disease Control and prevention, The Arc, and the National Inclusion Project. Additionally, MCPs must conduct staff training sessions on subjects including disability competency, access, cultural sensitivity, person-centered care delivery approaches and independent living philosophies (p. 17). Member materials must be printed in the prevalent non-English languages of members in the MCP's service area, be available in written format and alternative formats in an appropriate manner that takes into consideration special needs of the member including visually limited and limited reading proficiency members, and be provided in a manner and format that may be easily understood... ODM conducts an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent non-English languages in the MCP's service areas... ODM conducts an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent non-English languages in the MCP's service areas... ODM conducts an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent non-English languages in the MCP's service areas (p. 26). The MCP must utilize a centralized database which records the special communication needs of all MCP members; This database must utilize all MCP member primary language information as well as all other special communication needs information for all MCP members; This centralized database must be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available; The MCP must share specific communication needs information with its providers (p. 27, Ohio 2018 Draft Medicaid Managed Care Quality Strategy).

[145] Value-based Payment Models Ohio's goal is to have at least 80% of Ohio's population receiving services through a value-based payment model (combination of episodes-and population-based payment) within five years. Several strategies are currently being implemented to assist with this goal. Examples include: Paying (or withholding payment from) providers based on performance; Designing approaches to cut waste while preserving quality; Designing payments to encourage adherence to clinical guidelines (such as not paying for early elective deliveries) and Implementing payment strategies to reduce unwarranted price variation. The Ohio Department of Medicaid has joined the Governor's Office of Health Transformation to engage public and private sector partners in designing a new health care delivery payment system that rewards the value of services – not the volume. Ohio's State Innovation Model (SIM) grant centers on testing payment models that increase access to comprehensive primary care and support retrospective episode-based payments for acute medical events (p. 50-51, Ohio 2018 Draft Medicaid Managed Care Quality Strategy).

[146] Nine (10) CCOs in OR include some mention of access, five (5) include some mention of comprehensiveness/social determinants, ten (10) include some mention of care coordination and care management, and fifteen (15) include some mention of payment reform. For more on Oregon's CCO structure, please see note §§.

[147] 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 (p. 20). Each PH-MCO would: 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 10-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 (p. 24). 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: 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) (p. 79). CHIP Performance Objectives. 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 (p. 85, Pennsylvania 2017 Medicaid Managed Care Quality Strategy).

[148] 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 (p. 201, Pennsylvania 2017 Medicaid Managed Care Quality Strategy).

[149] Members are connected with a medical home to coordinate and manage services and assist in referrals and system navigation (p. 21). These include key initiatives such as: … coordinated physical health and behavioral health quality improvement projects implementation of community-based care management teams, and patient-centered medical homes (PCMH) (p. 8). OMAP continues to support the PH-MCOs to further develop CBCM programs that are focused on …enhancing behavioral and physical health coordination of services [and targeting] providers/organizations that serve a large volume of complex MA beneficiaries including high risk pregnant women (p. 24, Pennsylvania 2017 Managed Care Quality Strategy). For 2016, OMAP, in partnership with OMHSAS, began another incentive program [the ICP program] that fosters collaboration between the PH-MCOs and county/BH-MCOs (p. 24-25). 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 (p. 32). 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 (p. 33). Telephonic Psychiatric Consultation Services 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 (p. 34). The PHMCO will work collaboratively with the appropriate behavioral health MCO to coordinate comprehensive services" for opioid disorders (p. 34). The commonwealth plans to coordinate health and LTSS through CHC [a program for older recipients of LTSS] managed care organizations (p. 57-58). Goal 2 [for CHCs, a program for older LTSS recipients]: Strengthen coordination of LTSS and other types of

health care, including all Medicare and MA services for dual-eligibles (p. 60). ACAP was designed as an integrated service delivery system to provide physical, behavioral, and community-based services to adults with autism (p. 101). 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 (p. 106). 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….. The requirement for PHMCOs to develop new programs and provide updates to current programs continues as a requirement under the HealthChoices agreement into 2017 (p. 20). 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 (p. 18, Pennsylvania 2017 Medicaid Managed Care Quality Strategy).

[150] 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 (p. 18). 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 (p. 34). 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 (p. 83). 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 (p. 107, Pennsylvania 2017 Medicaid Managed Care Quality Strategy).

[151] 2. Assessment d. National Performance Measures. 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 (p. 20). 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 (p. 22). 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 (p. 28). 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 (p. 32). 2 Assessment, f. CHIP Performance Objectives. 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 (p. 86, Pennsylvania 2017 Medicaid Managed Care Quality Strategy).

[152] Representation on [a Health Education Advisory] 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 (p. 18). 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. … 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 PHMCOs post this information on their web sites…. 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) (p. 19-20). 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 (p. 84, Pennsylvania 2017 Medicaid Managed Care Quality Strategy).

[153] 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 overreaching 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; and c .Calendar year 2019 – 30 percent of the medical portion of the capitation and maternity care revenue rate must be expended through VBP strategies (p. 16). 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 (p. 21, Pennsylvania 2017 Medicaid Managed Care Quality Strategy).

[154] RIte Smiles was designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care, and decrease Medicaid expenditures for oral health care. To achieve these goals, Rhode Island transitioned from functioning simply as a payer of services to becoming a purchaser of a new oral health delivery system, a dental benefit manager (DBM) program provided by United Healthcare-Dental. Among other responsibilities, the DBM program was charged with: Increased preventive dental care and services (p. 12). Connect Care Choice was implemented under Section 1915(a) of the Social Security Act and was incorporated into the 1115 Waiver on January 16, 2009. The goal of CCC is to improve access to primary care, help coordinate health care needs, and serve as a critical link to support services in the community (p. 15). Promotion of Primary Care. A major objective of managed care is to promote the utilization of primary care services. The primary care provider serves as the recipient's medical home providing primary care services and coordinating the delivery of specialty care as well as other required services. The Health Plan contracts reinforce the importance of primary care and require Health Plans to: Ensure that Members Select or are assigned a Primary Care Provider (PCP). Though the role and responsibility of the PCP is broad, the PCP primarily serves as the member's medical home and refers members to require in- and out-of-plan specialty services. No more than 1,500 Medicaid members may be assigned to a single PCP within the team or site; Provide a Comprehensive Array of Primary Care and Preventive Services. Primary care means all health care services and laboratory services customarily furnished by or through a primary care provider. Health Plans are also required to provide a full range of preventive and comprehensive services; Further the Evolution of Primary Care: Medical Homes. A primary goal of the State in the current contract period is to enhance the provision of high-quality value-based care for Medicaid members. Health Plans are expected to implement programs and a strategy to assure that cost-effective, value-based care is provided to Medicaid members (p. 29-30). Network Adequacy and Timeliness of Care. Across all of its provider relationships, each Health Plan is required by contract to meet specific standards with respect to provider coverage and timeliness of care. Performance of these standards is monitored and reflected in the following ways: Meet Service Accessibility Standards. Health Plans must provide 24 hours, seven days per week coverage to members, either directly or through the PCPs. PCPs are required to have a back-up plan when they are not available. Access to emergency medical services must be available to members twenty-four (24) hours/day, seven (7) days/week. Treatment for an urgent care condition must be provided within twenty-four hours. Treatment or diagnosis of a non-urgent, non-emergent mental health or substance abuse condition must be made available within five (5) days. Treatment for all other non-emergent conditions must be available within thirty (30) days. Women may have direct access to women's health specialists for women's routine and preventive services. Members may also obtain a second opinion by a non-participating network provider at no cost to the member (p. 30). Safety-Net Providers and Continuing Care Relationships. Safety-net providers, such as Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs) have traditionally played a crucial role in serving the distinctive needs of underserved populations. Recognizing the expertise associated with this distinctive role, the State has required the Health Plans to contract with these providers, unless it can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations to serve the expected enrollment in a service area without doing so. The Health Plans may designate FQHC sites as PCPs (p. 30). Assurance of Adequate Capacity and Services. No more than 1,500 RIte Care members for any single PCP in a Health Plan network; No more 1,000 RIte Care members per single PCP within the team or site; Members may self - refer for up to four GYN/family planning (FP) visits annually or for FP services, without obtaining a referral from the PCP (p. 33). Coverage and Authorization of Services. Assignment of a PCP within 20 days of enrollment, if none selected by the enrollee (p. 33, Rhode Island 2014 Medicaid Managed Care Quality Strategy).

[155] One of the key features of Rhode Island's Medicaid managed care program is care coordination and care management. The goal of these efforts is to help ensure that members' needs are identified and met as best as possible. This takes a variety of forms, and ranges from supports to members in navigating and accessing care; assistance in managing complex needs and co-occurring conditions; disease management programs, and prevention and wellness initiatives (p. 20). The State's aims in this area have been to: Make available to members across Rhode Island a comprehensive and responsive provider network centered on primary and preventive care and comparable in scope and coverage to that available to commercial MCO members; Continue and strengthen the availability of traditional safety-net and other providers with on going patient relationships and/or particular expertise in regard to issues of particular concern in the Medicaid population, such as those associated with poverty, disability, or social, linguistic or cultural barriers to care… (p. 29). These goals are based on a commitment by the State to incorporate the following principles in the Rhode Island Medicaid program: Prevention, Wellness, and Independence initiatives to reduce the incidences of illness and injuries and their associated costs; Attention to the Social Determinants of Health (p. 5, Rhode Island 2014 Medicaid Managed Care Quality Strategy).

[156] The State's aims in this area have been to: Make available to members across Rhode Island a comprehensive and responsive provider network centered on primary and preventive care and comparable in scope and coverage to that available to commercial MCO members; Continue and strengthen the availability of traditional safety-net and other providers with ongoing patient relationships and/or particular expertise in regard to issues of particular concern in the Medicaid population, such as those associated with poverty, disability, or social, linguistic or cultural barriers to care; Improve the coordination of services among providers involved with the same patient; Develop responsive and well-integrated systems of care as new models emerge (p. 29). The goal of these efforts is to help ensure that members' needs are identified and met as best as possible. This takes a variety of forms, and ranges from supports to members in navigating and accessing care; assistance in managing complex needs and co-occurring conditions; disease management programs, and prevention and wellness initiatives (p. 19-20). Each Health Plan contracts with a Pharmacy Benefit Manager to process the point-of-sale pharmacy claims, send alerts to the pharmacists for possible harmful drug interactions (p. 31). Objective: All enrollees in the Demonstration will have a medical home; Illustrative Measures: Practice participation in multi- payer medical home initiative, Primary care practitioner (PCP) assignment, Child and Adolescent to PCPs, Adult Access to Prev./Ambulatory Health Services (p. 9). "The Chronic Care Sustainability Initiative (CSI) is Rhode Island's all-payer patient-centered medical home program (p. 51). The goal of the State's Integrated Care Initiative (ICI) is to build on the Rhody Health Partners and Connect Care Choice programs through the integration of acute care services, primary care, and long-term services and supports (LTSS) (p. 53). These goals are based on a commitment by the State to incorporate the following principles in the Rhode Island Medicaid program: Integrated Physical and Behavioral health (p. 5). The contract further requires the MCO to have defined methods to promote access to behavioral health care and for early identification of those with behavioral health needs (p. 31). Objectives of the care management program include Identification of care management needs that may be present upon Health Plan enrollment, Provision of short or intensive care management services to those in need of such services, Shared decision making, Incorporation of care management into all Health Plan operations, [and] Identification of strengths as well as risks that may affect the member (p. 20). Core components of the Care Management program" include an "Initial Health Screen within 45 days" and "Care Management Plan[s]" (p. 20). The [Communities of Care] Program consists of three key components: (1) enriched care management and peer navigation supports to educate and assist members to access alternatives to ERs, when appropriate; (2) designated providers to serve members who use multiple providers or have complex medical conditions [third component omitted] (p. 11). RI Medicaid is responsible for ensuring that the following... assurances that pertain to 1915(c) home and community-based waiver services are met: 1) Level of Care Determination: Person enrolled has needs consistent with the designated level of care evaluation, 2) Service Plan: Participants have a service plan that is appropriate to their need and receive the services and supports outlined in their plan (p. 46). Program implementation of disease management and health promotion programs require the development of health risk assessments, member and provider education materials and ongoing interaction and outreach to members. These voluntary programs are staffed by teams of registered nurses, behavioral health clinicians, and social workers to help members get the care they need when they need it (p. 35). The first step in the care management process is outreach to a new member in order to conduct an Initial Health Screen, or Health Risk Assessment. This screening is intended to identify members with needs that require action (p. 20). These goals are

based on a commitment by the State to incorporate the following principles in the Rhode Island Medicaid program: Care Coordination and Care Management efforts focused on the highest utilizers of care... Attention to the Social Determinants of Health (p 5). One of the key features of Rhode Island's Medicaid managed care program is care coordination and care management. The goal of these efforts is to help ensure that members' needs are identified and met as best as possible. This takes a variety of forms, and ranges from supports to members in navigating and accessing 20 care; assistance in managing complex needs and co-occurring conditions; disease management programs, and prevention and wellness initiatives. The health plans' contract outlines specific care management timelines and expectations, including the specific staff qualifications required at each phase of the care management process (e.g., nurses (RNs), Licensed Independent Clinical Social Workers (LICSW), etc.). These requirements are outlined in the contract specifically for children with special health care needs and members of Rhody Health Partners. The State defines children with special health care needs as blind/disabled individuals up to the age of twenty-one, Katie Beckett children up to age nineteen eligible under Section 1902 (e) (3) of the Social Security Act, individuals up to age twenty-one receiving subsidized adoption, and children in substitute care. The State defines adults with special health care needs as adults twenty-one years of age and older who are categorically eligible for Medicaid, not covered by a third-party insurer such as Medicare, and residing in an institutional facility (p. 19-20). Level 2 Needs review within 30 days of either the Initial Health Screen and/or Level 1 review: The purpose of the Level 2 Needs review is to explore further the circumstances and factors that place a member at risk. The Level 2 review consists of advance care planning, chronic care management, medication management, functional status, and transition from adolescence to adulthood (p. 20). Performance Goal Program for Rhody Health Options: Care Management: Care plans clearly demonstrate adequate and appropriate care and service plan, including social and environmental supports, shared decision making, involvement of the member and/or caregiver in plan development, and assessment of member goals and preferences (p. 59). The CCCCP program addresses the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services through high touch care coordination via a contracted Coordinating Care Entity (CCE) (p. 59, Rhode Island 2014 Medicaid Managed Care Quality Strategy).

[157] The CoC program consists of three key components: … (3) a Healthy Rewards Program to provide incentives that promote members' participation in the health care program (p. 11). The Care Management Plan should outline the identified key issues, including medical and social service needs and involve members and their caregivers in the setting of specific and actionable goals and action steps, including self-management education and techniques (p. 20-21). In addition, specific benchmarks regarding member engagement and care management are included as part of Rhode Island Medicaid's Performance Goal Program (p. 21). Figure 2 …patient engagement components … Care Management Reports, Patient Activation Measure, Community Health Team Registry, and Member Incentive Programs (p. 24). The CCCCP primary care practice network consists of practices that have adopted the "chronic care model" and are certified as a "patient-centered medical home" by NCQA. In addition, these practices must meet a high standard of performance, provide evidenced-based chronic disease management, nurse care management, primary and preventive care while encouraging self-management supports and education (p. 62, Rhode Island 2014 Medicaid Managed Care Quality Strategy).

[158] V. Quality Improvement via Cross-Cutting Initiatives. B. Chronic Case Sustainability Initiative. The Chronic Care Sustainability Initiative (CSI) is Rhode Island's all-payer patient-centered medical home program. CSI currently includes 48 practice sites, with over 300 primary care providers serving 220,000 Rhode Islanders (approximately 20% of the State's population.) CSI recently announced its fifth expansion and plans to add 20 new practices serving an additional 100,000 Rhode Islanders. With the expansion, approximately 30% of the State's population (and approximately 40% of the adult population) will have access to high performing patient-centered medical homes through CSI. One of the contractual requirements of the CSI program is the quarterly production and reporting of a set of standardized quality metrics from Electronic Health Record (EHR). FQHCs, some of which are also CSI sites, have submitted emergency visit rates to Medicaid. Practices submit these reports (numerators and denominators) to a central program management entity for aggregation, feedback, and display. A website available only to program participants displays each practice's measures over time, along with CSI aggregate totals. CSI has also established a "measure harmonization" process by which all of the payers participating in the program agree upon the metrics, their specifications, and the benchmarks for achieving contractual requirements. Currently, the following metrics are reported by type of payer (commercial, Medicare Advantage, RIte Care and Rhody Health Partners) in aggregate and by practice site: All Cause Admission (Number of Inpatient Admissions in three year rolling average per 1,000 member months); Ambulatory Care Sensitive Conditions (ACSC) Admissions (Number of ACSC in rolling year per 1,000 member months); All Cause ER Visit Rate (Number of ER visits in rolling year per 1,000 member months); Preventive ER Visit Rate (Number of Preventable ER visits in rolling year per 1,000 member months); Readmission Percent (Percent of Discharges in rolling year resulting in 30-day readmission); and Observation Stay Rate (Percent of Observation Stays in rolling year per 1,000 member months). In addition to the utilization metrics described above the CSI practices collect a set of clinical quality measures as shown in Appendix 3. CSI-RI is one RI Medicaid delivery system that is designed to provide beneficiaries with the right services, in the right setting, and at the right time. The program is structured to care for beneficiaries with complex healthcare needs. The data analytic functions of CSI-RI will enable Medicaid to measure whether there is increased access to and improved quality of care for Medicaid recipients enrolled in the program and compare rates to recipients receiving care via other delivery systems (p. 51, Rhode Island 2014 Medicaid Managed Care Quality Strategy).

[159] The Health Risk Assessment includes the following domains: …The family's cultural and linguistic needs, preferences, or limitations (p. 20). At the time of enrollment individuals are asked to report their race and ethnicity and language. These data are captured in an enrollment file and can be linked to MMIS claims data and analyzed. This data is used to ensure the delivery of culturally and linguistically appropriate services to Health Plan members. For example, Health Plans are required to provide member handbook and other pertinent health information and documents in languages other than English, including the identification of providers who speak a language other than English as well as to provide interpreter services either by telephone or in-person to ensure members are able to access covered services and communicate with their providers. In addition, Health Plans are obligated to adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability (p. 21). The State's aims in this area have been to:… Continue and strengthen the availability of traditional safety-net and other providers with ongoing patient relationships and/or particular expertise in regard to issues of particular concern in the Medicaid population, such as those associated with poverty, disability, or social, linguistic or cultural barriers to care (p. 29, Rhode Island 2014 Medicaid Managed Care Quality Strategy).

[160] Goal 1: Assure appropriate access to care (p. 21). Objective 1.2: TennCare will establish and begin monitoring travel time standards to augment existing travel distance standards for primary care (adult and pediatric), OB/GYN, behavioral health, specialist (adult and pediatric), hospital, pharmacy, and pediatric dental networks. By 2019, each managed care plan will have achieved 100% compliance or have an approved corrective action plan on file (p. 21). State standard for timely access to care and services. Primary Care Physician or Extender: Rural – 30 miles; Urban – 20 miles; Patient Load – 2,500 or less for physician; one-half this for a physician extender; Appointment/Waiting times – Not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes; Documentation – Plans must have a system in place to document appointment scheduling times (p. 70). CRA § 2.17.4.6 requires that each member handbook include the following: Information on how to access the primary care provider on a 24-hour basis as well as the 24-hour nurse line. The handbook may encourage members to contact the PCP or 24-hour nurse line when they have questions as to whether they should go to the emergency room (p. 85). Goal: Access to Care. Objective: Adult's access to preventive/ambulatory health services. Intervention: Distribution of Member Materials: MCOs distribute a large number of educational and informational materials to their membership, including but not limited to member handbooks, newsletters, fact sheets, and brochures. Each MCO is required to receive prior written approval from TennCare of all materials that are distributed to members, whether developed by the MCOs or their contractors. TennCare staff reviews the submitted materials for both clinical and programmatic content and either approves or denies them within 15 calendar days from the date of submission. QO staff works closely with the MCOs regarding continual quality improvement of materials developed (p. 96). Goal: Access to Care. Objective: Children & adolescents' access to primary care. Intervention: MCC EPSDT (TennCare Kids) Collaborative: The Division of Quality Oversight will continue to host ad hoc MCC EPSDT (TennCare Kids) collaborative meetings that include representatives from all MCOs, the Dental Benefits Manager, and the Department of Health. This group addresses ways of reaching out to TennCare enrollees who are under the age of 21 as well as to their families (p. 96). Objective: Children and adults visit doctor/clinic when first seeking care as opposed to hospital/ED (p. 96, Tennessee 2017 Medicaid Managed Care Quality Strategy).

[161] Collaborating with TennCare to develop and implement adult and child health disparities ("opportunity gaps") surveys (p. 42). Improve the health of the United States population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care (p. 20-21, Tennessee 2017 Medicaid Managed Care Quality Strategy).

[162] Goal: Access to Care; Objective: Children and adults visit doctor/clinic when first seeking care as opposed to hospital/ED (p. 97). Objective 1.3: By 2019, at least 35% of TennCare members will be cared for through a Patient Centered Medical Home (PCMH) model. By 2019, PCMH family practices, pediatric practices, and adult-only practices will be measured on 17, 10, and 8, quality metrics, respectively, and providers will be given quarterly updates on how their performance compares to their peers statewide. (p. 21). Health Information Technology efforts: Care Coordination Tool: 5) Tennessee has developed a shared Care Coordination Tool that will allow providers participating in the Patient Centered Medical Home (PCMH) and Tennessee Health Link programs to be more successful in the state's new payment models. The tool will identify and track the closure of gaps in care linked to quality measures. It will also allow providers to view their member panel and members' risk scores, which will facilitate provider outreach to members with a higher likelihood of adverse health events. The tool will also enable users to see when one of their attributed members has had an admission, discharge, or transfer from a hospital, such as a visit to the emergency room, and track follow-up actions. The Care Coordination Tool was rolled out to PCMH and Tennessee Health Link providers in February 2017. In 2018, the tool will be made available to additional Tennessee primary care providers who wish to participate in the State's strategies. 6)Integration of Behavioral Health Services with Primary Care Services: This project is designed to provide an electronic holistic view of an enrollee's care to providers and is currently in the developmental phase (p. 18). TennCare exchanges full Medicaid enrollment files with all D-SNPs to assure they are aware of the member's Medicaid MCO assignment (p. 42-43). Plans of Care are reviewed/updated at least annually (26). Asthma Medication Management Project: TennCare staff participate in a statewide asthma workgroup. The goal of the workgroup is to reduce the number of Emergency Department (ED) visits for children that are due to asthma related complications. The workgroup is convened by the Department of Health and is composed of TennCare staff as well as staff from MCOs, hospitals, pharmacy and the Department of Health. Subcommittees work on various issues such as enhanced care coordination and enhanced asthmas education (p. 100). Additionally, TennCare is directly working to reduce healthcare disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. These requirements include: Requiring opt-out Population Health services to be available to all TennCare members while providing intensive case management to those high-risk members who choose to opt-in to certain aspects of the program (p. 41) Beginning in January 2013, a phased in implementation of the new [population health] model began with full implementation occurring in July 2013… Under the new Population Health model, the entire TennCare population for each MCO is identified/stratified into the …. seven programs, with specific minimum interventions required for each (p. 111). The following are other interventions conducted by TennCare Managed Care Organizations. Diabetic self-management care plans for topics such as foot care, signs and symptoms of hyper/hypoglycemia, management of co-morbidities, management of diabetes when they are ill (p. 102). Integration of Behavioral Health Services with Primary Care Services: This project is designed to provide an electronic holistic view of an enrollee's care to providers and is currently in the developmental phase (p. 18). The key component of the CHOICES program is person-centered care coordination. The "whole person" care coordination approach includes: Implementation of active transition and diversion programs for people who can be safely and effectively supported at home or in another integrated community setting outside the nursing home; and Installation of an electronic visit verification system to monitor home care access, timeliness and quality through the use of GPS technology, and to immediately address potential gaps in care (p. 14). The [care coordination tool] will allow providers to coordinate their attributed patients' care across primary and behavioral health providers. Subsequently, claims data will be populated with the HIE data to allow for a common risk score, identify gaps in care and present to providers a patient register (history, medications, etc.) (p. 17). Care Coordination Tool: Tennessee has developed a shared Care Coordination Tool that will allow providers participating in the Patient Centered Medical Home (PCMH) and Tennessee Health Link programs to be more successful in the state's new payment models. The tool will identify and track the closure of gaps in care linked to quality measures. It will also allow providers to view their member panel and members' risk scores, which will facilitate provider outreach to members with a higher likelihood of adverse health events. The tool will also enable users to see when one of their attributed members has had an admission, discharge, or transfer from a hospital, such as a visit to the emergency room, and track follow-up actions. The Care Coordination Tool was piloted with nine practices from across Tennessee in the summer of 2016. Based on feedback from providers, additional enhancements and customization were made to the tool prior to launch and additional enhancements have been scheduled for future releases. The Care Coordination Tool was rolled out to PCMH and Tennessee Health Link providers in February 2017. In 2018, the tool will be made available to additional Tennessee primary care providers who wish to participate in the State's strategies (p. 18, Tennessee 2017 Medicaid Managed Care Quality Strategy).

[163] Other components of CHOICES include… Consumer-directed care options, including the ability to hire non-traditional providers like family members, friends, and neighbors with accountability for taxpayer funds (p. 14). A process has been implemented for sending educational letters to Medicaid members in advance of their attaining Medicare eligibility to encourage them to enroll in an aligned D-SNP (p. 42). To meet the objective of adult's access to preventive/ ambulatory health services… MCOs distribute a large number of educational and informational materials to their membership, including but not limited to member handbooks, newsletters, fact sheets, and brochures (p. 96). Objective… child and adolescent access to primary care… the Division of Quality Oversight will continue to host ad hoc MCCEPSDT (TennCare Kids) collaborative meetings that include representatives from all MCOs, the Dental Benefits Manager, and the Department of Health. This group addresses ways of reaching out to TennCare enrollees who are under the age of 21 as well as to their families (p. 96). Lack of member engagement in chronic condition programs, wellness programs, and even complex case management programs continues to be a barrier to positive outcomes, both nationally and the TennCare population. Proven programs can be implemented but fail if members cannot be engaged. TennCare MCOs, as well as national research, have identified several reasons for lack of engagement by the Medicaid population. Lack of correct or current phone numbers is always the first barrier listed. Medicaid members are very mobile; they change phone numbers and discontinue use of cell phones frequently. Health plans have found this to be true even when the attempt is made one day after receiving the number. When using traditional identification methodologies, there is often a significant lag time between diagnosis and engagement attempts. Members are much more receptive to help at the time of diagnosis. Psychosocial issues also affect engagement rates. If a member has a behavioral health problem, lack of housing and food, or low self-worth, engaging them in health issues is difficult. Another concern for those attempting to engage Medicaid members in continuing program is the fact that many want their immediate needs met and are not receptive to addressing long-term issues. Often initial engagement occurs but retention in a program does not. The last barrier identified is discovering the right message for the targeted audience. This is extremely difficult and varies tremendously among subpopulations. All TennCare health plans use motivational interviewing techniques in an attempt to engage their members. They are also testing engagement techniques such as social media, face-to-face engagement, focus group approaches, and telephonic strategies (p. 123, Tennessee 2017 Medicaid Managed Care Quality Strategy).

[164] Strategy Goals and Objectives. Goal 2: Provide quality care to enrollees. Objective 2.4: By 2019, statewide HEDIS rates for the following child and adolescent immunization measures will improve to the national medians: MMR: from 88.46% to 90.93%; Combo 1 (Meningococcal and Tdap/Td): from 67.13% to 73.15%; and Influenza: from 42.86% to 51.34%. Data Source: HEDIS/CAHPS; Report: A Comparative Analysis of Audited Results from TennCare MCOs (p. 22, Tennessee 2017 Medicaid Managed Care Quality Strategy).

[165] The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. Based on the linguistic need of its subscribers, the organization provider interpreter or bilingual services in its Member Services Department and telephone functions (p. 59). TennCare has taken steps to identify the age, race, ethnicity, sex, primary language, and disability statuses for each enrollee at the time of enrollment. Eligibility for TennCare and other Medicaid programs is determined by TennCare and the Federally Facilitated Marketplace (FFM). The application includes questions about age, race, ethnicity, sex, primary language, and disability statuses and instructs the applicant that responses to the race and ethnicity questions are voluntary…. The MCOs and their providers and subcontractors that provide services to members participate in TennCare's efforts to promote the delivery of services in a culturally competent manner to all

enrollees, including those with Limited English Proficiency, disabilities, and diverse cultural and ethnic backgrounds regardless of a member's gender or sex status. This includes the MCOs emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing services to members with physical or mental disabilities (p. 41, Tennessee 2017 Medicaid Managed Care Quality Strategy).

[166] Pay-for-performance or value-based purchasing initiatives. TennCare has been providing performance incentives, based on improvement to specific HEDIS measures, to the MCOs for several years. As a result of the Quality Redesign meetings conducted in 2015, the Quality Incentive performance measures were re-evaluated. The following measures were included in the July 2015 Contractor Risk Agreement (CRA) for payment year 2016 and will continue for at least three years. These measures were selected because all three (3) MCOs scored below the 25th percentile of the National Medicaid Average. The MCOs intend to use the same incentive measures, as appropriate, in provider contracts. The EPSDT measure was selected because of performance as reflected in the CMS 416 report. The measures are: Timeliness of Prenatal Care; Postpartum Care; Medication Management for People with Asthma – 75% measure; Diabetes – Nephropathy, Retinal Exam, and BP; Follow-up Care for Children Prescribed ADHD medication-initiation phase; and Follow-up Care for Children Prescribed ADHD medication – continuation phase. Both initiation and continuation measures have to be calculated in order to receive the quality incentive payment; Adolescent Well-Care Visits; Immunizations for Adolescents – Combo 1; Antidepressant Medication Management – acute and continuation; and EPSDT screening ratio 80% or above (p.107, Tennessee 2017 Medicaid Managed Care Quality Strategy).

[167] Future Goals and Projects: Improving access by expanding the provider network and enhancing the timeliness of care (p. 30, Texas 2017 Medicaid Managed Care Quality Strategy).

[168] The STAR Kids Focus Study will include a focus on care coordination (p. 28) Discusses care coordination for only those aged 65+ or with a disability (p. 3). Managed care organizations are required to submit to HHSC their plans for targeting BCNs, including intervention strategies, and resources dedicated to care management of this group, allowing HHSC to better assess managed care organization progress in this area. (p. 22, Texas 2017 Medicaid Managed Care Quality Strategy).

[169] Minimum MCO Alternative Payment Model Thresholds To accelerate service delivery transformation from volume-based to value-based models, Texas has proposed MCO contract requirements to establish minimum levels of Medicaid and CHIP MCO payments to providers associated with alternative payment models (APMs). Beginning January 2018, the four-year targets are for 50% of payments to be associated with APMs and 25% linked to APMs in which providers accept some level of risk. Texas is adopting the Health Care Payment Learning and Action Network's APM Framework definitions for types of APMs (p. 31, Texas 2017 Medicaid Managed Care Quality Strategy).

[170] Quality Strategy Goal 2: Promote preventive care for women and children. Quality Strategy Objective: Develop a collaborative relationship with the UDOH Bureau of Health Promotion and ACOs to improve access to and implementation of prevention and treatment practices (p. 4-5). Goal 2: Utah is the state with the highest birth rate in the U.S. Preventive care for women and children is especially needed in this context. The Quality Strategy goal to promote preventive care for women and children will address this need through performance measures and collaboration with other partners to improve access to and implementation of prevention and treatment practices. This goal aligns with the National Quality Strategy priority to promote the most effective prevention and treatment practices (p. 7, Utah Medicaid Managed Care Quality Strategy).

[171] Goal 2: Promote preventive care for women and children (p. 5, Utah Medicaid Managed Care Quality Strategy).

[172] Goal 1: Promote effective coordination of care between ACOs and PMHPs (p. 5). The objectives for this goal in the Quality Strategy will effectively advance coordination of physical and behavioral health services for Medicaid members in Utah (p. 8). The Healthy Outcomes Medical Excellence Program (H.O.M.E.) is another example of how DMHF serves members with special health care needs. H.O.M.E. provides physical and mental health services for members with developmental disabilities and mental illness. There is no age limit for participation in the H.O.M.E. program. H.O.M.E. uses a "medical H.O.M.E." model and emphasizes coordination of care between mental and physical health care in the same setting. The program provides primary care, referrals to specialty care, psychiatric evaluations, psychotherapy, psychosocial rehabilitation, care coordination, and other needed services (p. 12). Each ACO is required to have policies and procedures to identify adults and children with special health care needs. ACOs provide information about primary care providers with training for members with special health care needs. They also ensure that there is access to appropriate specialty providers and assist with case management and coordination of care for members with special health care needs (p. 12). The four primary aims of the Utah Health Innovation Plan are: behavioral health integration; geriatric advance care planning... (p. 20, Utah Medicaid Managed Care Quality Strategy).

[173] The evaluation of incentive programs like the auto assignment incentive program will explore new methods for providing affordable care to Utah Medicaid members. Improving member access to meaningful ACO quality metrics seeks to drive down costs by helping members choose the plan with the highest value. This also aligns with the National Quality Strategy priority to ensure that patients are engaged in their care (p. 7-8, Utah Medicaid Managed Care Quality Strategy).

[174] The collection of the six preventive HEDIS measures of Postpartum Care Rate, Childhood Immunizations, Well-Child Visits, Breast Cancer Screening, Cervical Cancer Screening and Chlamydia Screening in Women will assist BMHC in measuring the achievement of Goal 2 in the Quality Strategy, "promote preventive care for women and children." Objective 2.1 states that ACOs will perform at or above the national average on these measures and that will ensure that Goal 2 in the Quality Strategy is effectively met. The other ACO quality measures (Immunizations for Adolescents, Use of Appropriate Meds for Asthma, Diabetes: A1c Testing, Diabetes: Eye Exam, Controlling High Blood Pressure, Caesarean Rate for Nulliparous Singleton Vertex, Percentage of Live Births less than 2,500 Grams, Hospital-Wide All-Cause Readmission Measure for Adults and Children, Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with URI, Use of Imaging for Low Back Pain and CAHPS survey for each population served) will assist the BMHC in determining the achievement of Goal 3 in the Quality Strategy, "Improve the access to and quality of services provided to Medicaid members in ACOs..." (p.14, Utah Medicaid Managed Care Quality Strategy).

[175] The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients (p. 2). Foster Care Program. The Department of Medical Assistance Services (DMAS) transitioned 300 foster care children into managed care in 2011 with legislative support from the Governor and General Assembly. The pilot was successful, and in 2012, the General Assembly endorsed the inclusion of children placed in foster care and those receiving adoption assistance into managed care. The goal of the expansion process was to provide improved access to preventive and coordinated health care (p. 7). Between March 1, 2015, and September 5, 2016, the number of pregnant women utilizing their dental benefits has steadily climbed to 8,875 members. This gave pregnant women enrolled in Medicaid and FAMIS MOMS the ability to receive appropriate benefits covered by the Smiles for Children program, including diagnostic, preventive, restorative, endodontic, periodontics and prosthodontic services, along with access to nonemergency transportation services to receive dental care and medically necessary oral surgeries (p. 8). In accordance with the regulation, DMAS establishes time and distance standards based on provider type and the characteristics and special needs of specific Medicaid populations. To that effect, DMAS has included contractual specifications for time and distance standards in the CCC Plus and Medallion 4.0 contracts to address these distinct populations. Travel time and distance is defined per line of business and as urban versus rural. For urban areas, each enrollee will have a choice of at least two providers of each service type located within no more than 30 minutes travel time from any enrollee unless the MCO has a Department-approved alternative time standard. Travel time will be determined based on driving during normal traffic conditions (i.e., not during commuting hours). Standards are also defined for rural areas, for Medallion 4.0 and CCC Plus members (p. 16). Network Adequacy Standards Include: Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions (p. 17). Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities (p. 20). Table 4 - DMAS Quality Dashboard. Health Aims: Build a Wellness Focused, Integrated System of Care. Goals: Strengthen access to primary care network (p. 31). Establishing comprehensive primary care relationships with these individuals will reduce ED visits and decrease hospital charges, while providing the right care in the best setting for the patient. Ultimately, a patient's relationship with his or her community-based, primary care providers will be supported and strengthened, leading to

improved adherence to treatment recommendations and continuity of care. Reinforcement of the proper use of the health care delivery system teaches and enables participants to have their needs met by making informed decisions and directly accessing appropriate care (p. 37, Virginia 2017 Medicaid Managed Care Quality Strategy).

[176] Member-Centered Goals: Children (3-18): Increase: Oral Health, Vision, Well Visits, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Improve Coordination: Department of Education (DOE), Department of Social Services (DSS), Virginia Department of Health (VDH), Department of Behavioral Health and Developmental Services (DBHDS) (p. 13). The expectations of the Medallion 4.0 Program include: Providing a seamless, one-stop system of services; Increasing appropriate use of screening and prevention services (p. 12) Consistent with its mission, the purpose of DMAS's Quality Strategy is to: Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion (p. 4). Within OHE, the Division of Multicultural Health and Community Engagement works with stakeholders to identify approaches to eliminate health inequities through a focus on social determinants of health as a key strategy to eliminate health inequities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status, and other social classifications (p. 39, Virginia 2017 Medicaid Managed Care Quality Strategy).

[177] The process shall require the MCO to, at a minimum: 1) Ensure that there is no interruption of covered services for members; 2) Accept the transfer of all medical records and care coordination data, as directed by DMAS; 3) Send service authorization data to support continuity of care for members transitioning between fee-for-service and CCC Plus (p. 22). To ensure there is no interruption of any covered services for enrollees, policies and procedures will be developed by the MCO to ensure continuity of care for all enrollees (p. 24). DMAS's Quality Strategy provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system (p. 3). The Behavioral Health Home (BHH) pilot program includes adult members over the age of 21 who have a serious mental illness or a serious emotional disturbance. These health homes adopt a "whole person" philosophy for treatment that calls for team-based care of all primary, acute, behavioral health, and some substance abuse services (p. 8-9). CCC blends all of the benefits currently provided under Medicare and Medicaid into one plan with a designated care manager who will ensure person-centered and efficient health care services are provided." Under CCC there were provisions for "person-centered care planning, interdisciplinary care teams, care coordination services, [and], access to services" (p. 10). CCC Plus [a program for children and adults with disabilities and complex care needs] is an integrated delivery model that includes care coordination and person-centered care with an interdisciplinary team approach to provide medical services, behavioral health services, and long-term services and supports. (p. 12). CCC plus includes Individualized care plans, Interdisciplinary care teams, assessments, and transition programs (p. 12). The expectations of the Medallion 4.0 Program include… Providing a seamless, one-stop system of services (p. 13). The purpose of DMAS's Quality Strategy is to…Provide a framework for DMAS to implement a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP systems (p. 4). Future efforts may include ED Care Coordination in which primary care relationships are established for high cost individuals (p. 38). The Model of Care Elements encompass: ... Interdisciplinary care teams, Individualized care plans, Care coordination (p. 11). In addition, the new program "carves in" the community-based addiction treatment services into MCOs to promote full integration of physical health, traditional mental health, and addiction treatment services (p. 37, Virginia 2017 Medicaid Managed Care Quality Strategy).

[178] The program themes and focus include a big quality, data, and outcome focus; maternal child health partnerships; behavioral health models; strong compliance and reporting; provider and member engagement; and innovation (p. 12). Encourage appropriate management of prescription medications… effective management of chronic respiratory disease…comprehensive management of diabetes… effective management of cardiovascular disease (p. 32, Virginia 2017 Medicaid Managed Care Quality Strategy).

[179] Establishing Quality Metrics and Performance Targets Used for Measuring Performance and Improvement. DMAS has identified clinical quality, access, and utilization measures for the CCC Plus and Medallion 4.0 programs using the nationally recognized measure sets listed in Table 4. DMAS includes a subset of HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures listed in the DMAS Quality Dashboard are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when relevant clinical guidelines are adhered to by each MCO's provider network. Additionally, when selecting measures for the specific needs of the populations (e.g., CCC Plus versus Medallion 4.0), DMAS takes into consideration the availability and reliability of the data that are used to calculate the measures. Table 4 – DMAS Quality Dashboard. Health Aims: Build a Wellness, Focused, Integrated System of Care (Goals: Strengthen access to primary care network; integration of behavioral, oral and physical health; Examples of measures: HEDIS/CMS/NQF.); Focus on Screening and Prevention (Goals: Prevention of nicotine dependency; Virginians protected against vaccine-preventable diseases; Support consistency of recommended pediatric screenings; Examples of measures: HEDIS/CMS/OHSU.); and Maximize Wellbeing Across the Lifespan (Goals: Effective management of chronic respiratory disease; comprehensive management of diabetes; effective management of cardiovascular disease. Examples of measures: PQI/HEDIS) (p. 31-32, Virginia 2017 Medicaid Managed Care Quality Strategy).

[180] The purpose of DMAS's Quality Strategy is to…Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Virginia Medicaid and CHIP recipients have access to high quality and culturally appropriate care (p. 4). The expectations of the Medallion 4.0 Program include…Ensuring the use of culturally, linguistically, and ability-appropriate consumer and family educational materials (p. 13). Each MCO must participate in DMAS's efforts to promote the delivery of services in a culturally competent manner to all enrollees (p. 20). DMAS understands that access to the decision-making process regarding the Medicaid and CHIP programs is especially critical for tribes for cultural, treaty, and statutory reasons. Therefore, DMAS's tribal consultation policy follows the federal requirements for tribal consultation. For example, DMAS notifies the tribe in writing at least 60 days prior to the State's submission of any Medicaid or CHIP State plan amendment, waiver request, or proposal for a demonstration project likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations (p. 44, Virginia 2017 Medicaid Managed Care Quality Strategy).

[181] MCO enrollees are encouraged to choose a PCP. If a PCP is not selected, the MCO assigns a PCP or clinic within reasonable proximity to the enrollees' home, no later than fifteen (15) working days after coverage begins. To ensure each MCO enrollee has an ongoing source of primary care, the PCP is responsible for provision, supervision and coordination of health care to meet enrollee needs (p. 19). The MCO, PIHP, and PCCM contracts require: Preventive care (i.e. Non-symptomatic) – MCO—available within 30 days; Routine primary care (i.e., Non-urgent, symptomatic) – MCO—available within 10 days; Routine services appointment from request to visit – PIHP—may not exceed 28 calendar days (p. 20, Washington 2017 Draft Medicaid Managed Care Quality Strategy).

[182] Ensure children receive adequate preventive care through measurable improvement in the quality and utilization of EPSDT services, including childhood immunizations (p. 12, Washington 2017 Draft Medicaid Managed Care Quality Strategy).

[183] Improve care coordination for individuals with complex behavioral and physical health needs through continued support and implementation of the Health Home and MCO/PIHP based care management services (p. 12). Improve transitions of care between health care entities and across settings and systems of health care services to promote optimal health of the Apple Health enrollee (p. 12). Through Health Home, care coordination is designed to ensure the enrollee is central in the development of a patient-centered health improvement plan (p. 13). By the conclusion of 2020, all counties will be converted to regional, integrated contracts within the state. Health care benefits, inclusive of physical and behavioral health care will be provided through this contract arrangement (p. 8). Presently there are four managed care contracts in place: Fully Integrated Managed Care (FIMC): Initiated by the Washington legislature, this program integrates physical and behavioral health (mental health and substance use disorder services) under one contract. By 2020, FIMC will be operational throughout the state and take the place of the AHBC program (p. 6). Washington uses a Predictive Risk Intelligence System (acronym, PRISM) to identify individuals who are

estimated to have 50% or higher costs in the succeeding 12 months based on the patient's disease profile and pharmacy utilization. These clients are referred for comprehensive care coordination/care management through the Health Home program (p. 27). These objectives are intended to ensure individuals receive evidence-based health care services, preventive care and optimal management of chronic conditions. The objectives include actions to improve health care delivery systems, such as the deployment of shared decision-making tools and use of patient decision aids in clinic settings. Through Health Home, care coordination is designed to ensure the enrollee is central in the development of a patient-centered health improvement plan and which supports transitions of care, optimizing health while reducing unnecessary care such as re-hospitalizations (p. 11). The Initial Health Screen is required to contain behavioral, developmental and physical health questions and if screening positive, conduct of an Initial Health Assessment to determine ongoing need for care coordination services and the need for clinical and non-clinical services including referrals to specialists and community resources (p. 25). The MCO, PIHP and PCCM contracts require: Transitional health care services by a primary care provider for clinical assessment and care planning within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program (p. 20). Following a House-Senate Adult Behavioral Health System Task Force report and a series of key Washington state legislation implemented: Fully integrated physical and behavioral health services in Southwest Washington in April 2016, followed by North Central Washington slated for January 2018 (p. 2). Fully Integrated Managed Care (FIMC): Initiated by the Washington legislature, this program integrates physical and behavioral health (mental health and substance use disorder services) under one contract. By 2020, FIMC will be operational throughout the state and take the place of the AHMC program (p. 4-5) Current interventions to address health disparities and assess members for social determinants of health include community referrals in care plan development, the Obstetric Medical Home, the HIV/AIDS Medical Home, and a DMS-wide cultural competency (p. 37, Washington 2017 Draft Medicaid Managed Care Quality Strategy).

[184] In collaboration with DSHS, Aging and Long-Term Support Administration and the Centers for Medicare and Medicaid, implemented the Health Home program. The program delivers a set of services to support chronically ill and complex clients. The program aims are to improve a client's self-management of health care conditions and better manage the progression of chronic disease. Initially delivered in 37 of 39 counties, the program underwent statewide expansion in the remaining two counties in 2017 (p. 3). Increase the use of shared decision-making into clinical practice, including the use of patient decision aids to help enrollees make informed decisions regarding their health care (p. 13, Washington 2017 Draft Medicaid Managed Care Quality Strategy).

[185] Goals for Continuous Quality Improvement HCA's Healthier Washington initiative guides the agency in its efforts to improve care to Apple Health enrollees. The Goals of Healthier Washington include: Building healthier communities through a collaborative regional approach, Integrating physical and behavioral healthcare to focus on the whole person, and Improving how the agency pays for services by rewarding quality over quantity (p. 9). Program Objectives: Continue to collect race and ethnicity data, as well as age, gender and special needs information in order to develop meaningful objectives for improving preventive and chronic care and reduce disparities in enrollee outcomes (p. 10, Washington 2017 Draft Medicaid Managed Care Quality Strategy).

[186] The MCO and PIHP contracts requires the delivery of culturally competent care and care coordination. Both contracts include definitions for cultural competent care with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care or CLAS Standards required in the MCO contract. Cultural considerations, including cultural strengths and community/family support are an integral source of information in developing a care management plan and facilitating care coordination activities (p. 27, Washington 2017 Draft Medicaid Managed Care Quality Strategy).

[187] Clinical Quality Metrics and Performance Targets for Value-Based Purchasing. These measures will be effective in all Apple Health managed care contracts effective January 2018. Table 1: Value-Based Purchasing Clinical Performance Measures by Plan Type (p. 8). MCOs can earn back up to 75 percent of the premium withhold based on their overall QI score. The remaining 25 percent premium withhold is earned back after MCOs provide evidence of passing qualifying, value-based provider incentive payments to subcontracted providers (p. 9, Washington 2017 Draft Medicaid Managed Care Quality Strategy).

[188] Acute Care Goal 1: Improve access to appropriate care for primary, behavioral health, and dental care (p. 17). DMS is working with MCOs to develop innovative technological solutions, including telemedicine and e-visits (p. 35, Wisconsin 2018 Medicaid Managed Care Quality Strategy).

[189] Foundational Principles: Evaluate and address health disparities: Consider the impact on health disparities when developing, implementing, and managing all programs and initiatives. This will include addressing social determinants of health and supporting access to community services and supports (p. 14-15, Wisconsin 2018 Medicaid Managed Care Quality Strategy).

[190] Wisconsin will continue to require BadgerCare and SSI HMOs to improve, manage, and coordinate care for specific populations using health homes (p. 23 [Note that the health home examples all appear to be inpatient see page 27]). The acute care program area will focus on reducing potentially preventable readmissions…by working with BadgerCare Plus and Medicaid SSI HMOS that serve members through managed care. This strategy is expected to promote appropriate access to care (i.e., primary care) (p. 22). Together, the interdisciplinary care team collaborates to identify the member's needs, develop long-term care and personal experience outcomes, and build the member-centered care plan. A dynamic document, the member-centered care plan is based on the initial comprehensive assessment and is updated through periodic assessments that minimally occur every six months or with a significant change in condition. The interdisciplinary care team is responsible for coordinating all services and supports, including coordination of all paid, natural, and medical supports (p. 22). WFCA suggests the following policy ideas that could promote access to care: Reduce administrative burdens on care teams so that more time can be spent with the member (p. 69, Wisconsin 2018 Medicaid Managed Care Quality Strategy).

[191] Member engagement and choice are critical strategies for promoting active participation of members in their own health care decisions (p. 9). [note this technically refers to long term and acute care goals but it appears to include primary care too]. supporting and encouraging members to… establish care with their selected or assigned primary care provider… proactively receive health screenings, preventative care, and immunizations, as appropriate… work with their HMO to complete a health needs assessment and a care plan, if needed to address their health needs (p. 24-25, Wisconsin 2018 Medicaid Managed Care Quality Strategy).

[192] Member engagement strategies involve providing culturally competent member services (p. 9, Wisconsin 2018 Medicaid Managed Care Quality Strategy) [note refers to long term and acute care goals, not specifically primary care].

[193] Presently, non-emergency transportation services are excluded from MCOs' capitation rates, but remain covered Medicaid services for persons who are enrolled in the MCO (the Bureau will continue to pay the transportation broker on a PMPM basis) (p. 8). Most importantly, BMS requires the MCOs to report HEDIS and CAHPS measures, which indicate the quality of care delivered by and enrollee satisfaction with the MHT program. More specifically, the MCOs must collect and report measures in the following areas: Access, availability and timeliness of care (e.g., access to primary care) (p. 21, West Virginia 2015 Medicaid Managed Care Quality Strategy).

[194] MCOs provide care coordination and case management (p. 1). Goal 4: Promote effective communication and coordination of care" (p. 3). "The MCOs will begin delivering the behavioral health benefit on July 1, 2015. Inclusion of the benefit will allow for increased coordination of behavioral health and medical services, which will improve overall quality of care for enrollees (p. 35). West Virginia will be implementing a health home model for individuals who are suffering from bipolar disorder and are at risk for Hepatitis B and/or C. The health home will deliver services that augment clinical care, including comprehensive care management and coordination and identification of appropriate community resources. The state may also implement additional health home models in the future (p. 30). All MHT MCOs have developed disease management programs to help enrollees with diabetes, asthma, and other chronic conditions live healthier lives. The programs are specifically designed to address disease

management issues commonly encountered by the Medicaid population. They incorporate self management education, member outreach, case management, and clinical support services. The programs engage patients in their care and promote effective care coordination (p. 30). Priorities and Goals: Promote effective prevention and treatment of diseases that burden MHT enrollees (p. 3). BMS decided to include the pharmacy benefit into the MHT program to improve the quality and coordination of care received by enrollees. Allowing the MCOs to administer the pharmacy benefit provides several opportunities for care improvement. For instance, the MCOs will be able to develop more complete care plans for enrollees since they will have access to all of the prescriptions the enrollee is taking (p. 34, West Virginia 2015 Medicaid Managed Care Quality Strategy).

[195] Goal 2… Engage individuals and families as partners in their care by strengthening the relationship between patients and their primary care provider (p. 3). Activities and Interventions … enrollment outreach … promote enrollee engagement in treatment plans (p. 6). All MHT MCOs have developed disease management programs to help enrollees with diabetes, asthma, and other chronic conditions live healthier lives. The programs are specifically designed to address disease management issues commonly encountered by the Medicaid population. They incorporate self management education, member outreach, case management, and clinical support services. The programs engage patients in their care and promote effective care coordination (p. 30, West Virginia 2015 Medicaid Managed Care Quality Strategy).

[196] Quality Improvement Programs. Performance Improvement Projects. Performance improvement projects (PIPs) are designed to achieve significant, sustained improvement in clinical or nonclinical care areas that are important to MHT enrollees. They are crucial pieces of MCO quality programs and allow specific areas of concern to be targeted for improvement. In SFY 2014, BMS increased the number of PIPs that MCOs are required to have in place from two to three. As part of this requirement, the state also required the MCOs to participate in two PIP collaboratives – one focused on improving diabetes care and one focused on reducing inappropriate usage of the emergency department. For these collaboratives, the MCOs will work together to implement coordinated interventions and use the same performance measures to track progress. As a 30 result, they present the opportunity to create system wide changes and even greater improvements in the quality of care delivered to enrollees. Each MCO also runs their own PIP project, which allows them to focus on the needs of their specific enrolled population. These PIPs focus on increasing compliance with adolescent well-care visits, improving childhood obesity care, and increasing compliance with childhood immunizations (p. 29, West Virginia 2015 Medicaid Managed Care Quality Strategy).