Commonwealth of Pennsylvania, Department of Human Services 2022 External Quality Review Report

Statewide Medicaid Managed Care Annual Report

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Overview

This report is a summary of Medicaid and CHIP managed care (MMC) external quality review (EQR) findings for the Commonwealth of Pennsylvania's behavioral health (BH), physical health (PH), Children's Health Insurance Program (CHIP), Community HealthChoices (CHC) managed care organizations (MCOs), and the Adult Community Autism Program (ACAP) Prepaid Inpatient Health Plan (PIHP). ACAP is currently a small program, with 183 members enrolled as of December 2021, and EQR findings for this program are presented in a separate section within this report.

For the Commonwealth of Pennsylvania (PA), MMC services are administered separately for PH services, for BH services, for CHIP services, for autism services, and for long-term services and supports (LTSS), as applicable. The HealthChoices Program is the Commonwealth of Pennsylvania's mandatory managed care program for Medical Assistance recipients. The HealthChoices Program has three subprograms detailed in this report: PH, BH, and LTSS.

The Pennsylvania (PA) Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) oversees the PH component of the HealthChoices Program. DHS OMAP contracts with PH-MCOs to provide physical health care services to recipients.

DHS's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the behavioral health (BH) component of the HealthChoices Program. OMHSAS determined that the Pennsylvania county governments would be offered "right of first opportunity" to enter into capitated contracts with the commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program, the mandatory managed care program that provides Medical Assistance (i.e., Medicaid) recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Effective July 1, 2021, 66 of the 67 counties exercised their right of first opportunity to contract directly with a primary contractor. In 2021, DHS held one contract on behalf of an opt-out county, Greene. Through these BH-MCOs, recipients receive mental health and/or drug- and alcohol dependence-related services.

Starting in 1997, the HealthChoices Program was implemented for PH and BH services using a zone phase-in schedule. The zones originally implemented were:

- **Southeast Zone** - Bucks, Chester, Delaware, Montgomery, and Philadelphia counties;
- **Southwest Zone** - Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington, and Westmoreland counties; and
- **Lehigh/Capital Zone** - Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties.

Expansion of the HealthChoices PH Program began in July 2012 with Bedford, Blair, Cambria, and Somerset counties in the Southwest Zone and Franklin, Fulton, and Huntingdon counties in the Lehigh/Capital Zone. In October 2012, HealthChoices PH expanded into the New West Zone, which includes Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, Mercer, McKean, Potter, Warren, and Venango counties. In March 2013, HealthChoices PH expanded further, into these remaining counties: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming. HealthChoices PH served more than 2.7 million recipients in 2021.

Starting in July 2006, the HealthChoices BH Program began statewide expansion on a zone phase-in schedule, incorporating additional zones to the original three listed above. The Northeast region's BH implementation went into effect in July 2006, followed by two North/Central implementations. The first North/Central implementation is a directly held state contract that covers 23 counties implemented in January 2007, followed by the second implementation of 15 counties that exercised the right of first opportunity and were implemented in July 2007. The counties included in each of these zones are indicated below:

- **Northeast Zone** - Lackawanna, Luzerne, Susquehanna, and Wyoming counties;
- **North/Central Zone – State Option** - Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne counties; and

- **North/Central Zone – County Option** - Bedford, Blair, Cambria, Carbon, Clinton, Crawford, Erie, Fulton, Franklin, Lycoming, Mercer, Monroe, Pike, Somerset, and Venango counties.

All Pennsylvania counties were covered by the HealthChoices PH Program in 2014, when it became mandatory statewide. For PH services in 2022, Medical Assistance enrollees had a choice of three to five PH-MCOs within their county (depending on the zone of residence).

The PH MCOs that were participating in the HealthChoices PH Program as of December 2022 were:

Physical Health MCOs

- Aetna Better Health (ABH)[*],
- AmeriHealth Caritas Pennsylvania (ACP),
- Geisinger Health Plan (GEI),
- Health Partners Plan (HPP),
- Highmark Wholecare (HWC)[+]
- Keystone First (KF),
- United Healthcare Community Plan (UHC), and
- UPMC for You (UPMC).

[*]Aetna Better Health's contract was terminated in MY 2022. The MCO reported all HEDIS and PA PM data for validation for MY 2021 but was not required to submit a second interim report for the Performance Improvement Projects currently underway. Where impacted, results in this report include a note that ABH's contract termination impacted final results for a section.

[+]Effective 1/1/2022, Gateway Health Plan began doing business as Highmark Wholecare. Their new name has been replaced by the former Gateway Health in all instances in this report.

The HealthChoices BH Program differs from the PH component in that, for mental health and drug and alcohol services, each county contracts with one BH-MCO to provide services to all enrollees residing in that county. The Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the county directly or counties can create an entity to oversee the services provided to members within those counties. The county or group of counties are referred to in this report as "Primary Contractors." In addition, DHS/OMHSAS may hold agreements directly, acting as the Primary Contractor for one county that chose not to exercise their "right of first opportunity." The HealthChoices BH Program is also mandatory statewide.

The BH-MCOs that were participating in the HealthChoices BH Program as of December 2021 were:

Behavioral Health MCOs

- Beacon Health Options of Pennsylvania (BHO)
- Community Behavioral Health (CBH),
- Community Care Behavioral Health (CCBH),
- Magellan Behavioral Health (MBH), and
- PerformCare.

Pennsylvania's Children's Health Insurance Program (CHIP) was established through passage of Act 113 of 1992, reenacted as an amendment to The Insurance Company Law of 1921 by Act 68 of 1998, amended by Act 136 of 2006, and amended and reauthorized by Act 74 of 2013 and Act 84 of 2015 (the Act), and as amended by Act 58 of 2017. It has long been acknowledged as a national model, receiving specific recognition in the Federal Balanced Budget Act of 1997 as one of only three child health insurance programs nationwide that met Congressional specifications.

In early 2007, after passage of Act 136 of 2006, Pennsylvania received approval from the federal government to expand eligibility for CHIP through the Cover All Kids initiative. As of March 2007:

- Free CHIP: Coverage has been available to eligible children in households with incomes no greater than 208% of the federal poverty level (FPL);
- Low-Cost CHIP: Coverage is available for those with incomes greater than 208% but not greater than 314% of the FPL; and
- At-Cost CHIP: Families with incomes greater than 314% of the FPL have the opportunity to purchase coverage by paying the full rate negotiated by the state.

In February 2009, the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) reauthorized CHIP at the federal level. Historically, federal funding paid for about two-thirds of the total cost of CHIP; however, under CHIPRA, CHIP's federal funds allotment was substantially increased. CHIPRA contained numerous new federal program requirements, including citizenship and identity verification, a mandate to provide coverage for orthodontic services as medically necessary, a mandate to make supplemental payments in certain circumstances to Federally Qualified Health Centers and Rural Health Clinics, a variety of process requirements when CHIP provides coverage through managed care plans, the obligation to provide information about dental providers to be used on a new federal website, and expanded reporting.

The Affordable Care Act (the Patient Protection and Affordable Care Act, together with the Health Care and Education Reconciliation Act of 2010; ACA), signed into law in March 2010, provided additional changes for CHIP. The ACA extended federal funding of CHIP through September of 2015, as well as added a requirement that states maintain the Medical Assistance (MA) and CHIP eligibility standards, methods, and procedures in place on the date of passage of the ACA or refund the state's federal stimulus funds under The American Recovery and Reinvestment Act of 2009 (ARRA). In December 2015, Governor Tom Wolf signed Act 84 reauthorizing CHIP through 2017 and moving the administration of CHIP from the Insurance Department to the Department of Human Services (DHS). As of July 1, 2018, the CHIP Managed Care Organizations (MCOs) were required to comply with changes to the federal managed care regulations (42 CFR chapters 457 and 438). CHIP continues to work with the CHIP MCOs to ensure organized and efficient implementation of these regulations. On January 22, 2018, the federal government passed a continuing resolution and adopted the Helping Ensure Access for Little Ones, Toddlers and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act). CHIP was authorized at the federal level, including funding appropriations through September 30, 2023. On February 9, 2018, Congress acted again to extend CHIP for an additional four years, or until September 30, 2027. CHIP is provided by the below private health insurance companies that are licensed and regulated by the Department of Human Services and have contracts with the Commonwealth to offer CHIP coverage. Approximately 132,000 children and teens were enrolled in PA CHIP as of December 2022.

CHIP-MCOs

- Aetna Better Health (ABH),
- Capital Blue Cross (CBC),
- Geisinger Health Plan (GEI),
- Highmark HMO,
- Highmark PPO,
- Health Partners Plan (HPP),
- Independence Blue Cross (IBC),
- First Priority Health (NEPA),
- United Healthcare Community Plan (UHC), and
- UPMC for Kids (UPMC).

The PA DHS Office of Long-Term Living (OLTL) oversees Community HealthChoices (CHC), which is PA's mandatory managed care program for LTSS. CHC is for adults aged 21 years and over, dually-eligible for Medicare and Medicaid, and for older adults, and adults with physical disabilities, in need of long-term services and supports (LTSS). LTSS includes services and supports in the nursing facility setting, as well as the home and community setting to help individuals perform daily activities in their home such as bathing, dressing, preparing meals, and administering medications. CHC aims to serve more people in communities, give them the opportunity to work, spend more time with their families, and experience an overall better quality of life. CHC was developed to improve and enhance medical care access and coordination, as well as create a person-centered LTSS system, in which people have a full array of quality services and supports that foster independence, health, and quality of life. CHC was being phased in over a three-year period: Phase 1 began January 1, 2018 in the Southwest region (Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties); Phase 2 began January 1, 2019, in the Southeast region (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties); and Phase 3 began January 1, 2020, in the remaining part of the state (Northeast [NE], Northwest [NW], and Lehigh Capital [L/C] Regions). Statewide, PA DHS OLTL contracts with CHC-MCOs to provide CHC benefits to members.

The CHC-MCOs that were participating in CHC as of December 2021 were:

Community HealthChoices MCOs

- AmeriHealth Caritas Pennsylvania (ACP CHC)/Keystone First (KF CHC),[1]
- Pennsylvania Health & Wellness (PAHW), and
- University of Pittsburgh Medical Center Health Plan (UPMC CHC).

These three CHC-MCOs have been contracted with DHS OLTL since the initial implementation of CHC in January 2018.

Introduction and Purpose

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an external quality review organization (EQRO) to conduct an annual EQR of the services provided by contracted Medicaid MCOs. This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a MCO furnishes to Medicaid recipients.

The EQR-related activities that must be included in the detailed technical reports, per 42 CFR §438.358 (cross walked to §457.1250 for CHIP), are validation of performance improvement projects, validation of MCO performance measures, and review to determine MCO compliance with Medicaid and CHIP managed care regulations established by the state. It should be noted that a fourth mandatory activity, validation of network adequacy, was specified in the CMS External Quality Review (EQR) Protocols published in February 2023. The 2023 protocols go into effect February 2024 and will inform the 2024 EQR technical reports due April 30, 2024. Because states have until February 2025 to fully implement Protocol 4 Validation of Network Adequacy, network adequacy results will be validated and reported according to the new Protocol 4 starting with the 2025 EQR technical report. This technical report uses the 2019 protocols released in October 2019.

DHS contracted with Island Peer Review Organization (IPRO) as its EQRO to conduct the 2022 (MY 2021) EQRs for the Medicaid and CHIP MCOs.

Information Sources

The following information sources were used by IPRO to evaluate the MCOs' performance:

- MCO-conducted Performance Improvement Projects (PIPs);
- Healthcare Effectiveness Data Information Set (HEDIS®) performance measure data, as available for each MCO;
- Pennsylvania-Specific Performance Measures (PAPMs); and
- Structure and Operations Standards Reviews conducted by DHS.

PH-, BH-, CHIP-, and CHC-MCO compliance results are indicated using the following designations in the current report:

Acronym	Description
C	Compliant
P	Partially compliant
NC	Not compliant
ND	Not determined
N/A	Not applicable

To evaluate the MMC compliance with the BBA categories, IPRO grouped the appropriate MCOs and assigned the compliance status for the category as a whole. Each MCO individually can be given a compliance status of compliant (C), partially compliant (P), not compliant (NC), or not determined (ND). Categories regarded as not applicable (N/A) to the applicable DHS entity are indicated as such. Each category as a whole was then assigned a compliance status value of C, P, NC, or ND based on the aggregate compliance of each of the applicable MCOs for the category. Therefore, if all applicable MCOs were compliant, the category was deemed compliant; if some MCOs were compliant and some were partially compliant or not compliant, the category was deemed partially compliant. If all MCOs were not compliant, the category was deemed not compliant. If none of the MCOs were evaluated for a category, the aggregate compliance status was deemed not determined.

Section I: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of PIPs for each Medicaid and CHIP MCO. According to CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (Validating Performance Improvement Projects*, CMS External Quality Review (EQR) Protocols,* published October 2019) and meets the requirements of the updated 2020 Final Rule on External Quality Review (EQR) of Medicaid Managed Care. IPRO's review evaluates each project against 10 elements:

1. Project Topic and Topic Relevance,
2. Study Question (Aim Statement),
3. Study Variables (Performance Indicators),
4. Identified Study Population,
5. Sampling Methods,
6. Data Collection Procedures,
7. Improvement Strategies (Interventions),
8. Interpretation of Study Results (Demonstrable Improvement),
9. Validity of Reported Improvement, and
10. Sustainability of Documented Improvement.

The first nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. IPRO's scoring for each element is based on full, partial, and non-compliance status. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.

All MCOs are required to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol, *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology,
- Data/Results,
- Analysis Cycle, and
- Interventions.

Overall Project Performance Score

For divisions for which weighted scoring is applicable, the total points earned for each review element are weighted to determine the MCO's overall performance score for a PIP. The review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance).

PIPs also are reviewed for the achievement of sustainability of documented improvement. This has a weight of 20%, for a possible maximum total of 20 points. The MCO must sustain improvement relative to baseline after achieving demonstrable improvement.

Scoring Matrix

For PH, BH, CHC, and CHIP, when the PIPs are reviewed, all projects are evaluated for the same elements according to the timeline established for that PIP. For all PIPs, the scoring matrix is completed for those review elements where activities have occurred in the review year. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of met, partially met, or not met. Elements receiving a finding of met will receive 100% of the points assigned to the element, partially met elements will receive 50% of the assigned points, and not met elements will receive 0% of the assigned points.

As part of the new EQR PIP cycle that was initiated for all CHIP-MCOs in 2017, for all CHC-MCOs in 2018, and for all BH-MCOs and PH-MCOs in 2021, IPRO adopted the LEAN methodology, including re-developed templates for submission and evaluation. These updated methodologies, including how review elements are grouped, are further described in these programs' PIP Review subsections, below.

PH-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each Medicaid PH-MCO. For the purposes of the EQR, PH-MCOs were required to participate in studies selected by OMAP for validation by IPRO in 2022 for 2021 activities. Under the applicable HealthChoices Agreement with the DHS in effect during this review period, Medicaid PH-MCOs are required to conduct focused studies each year. For all PH-MCOs, two PIPs were initiated as part of this requirement in 2021 and continued in 2022. For all PIPs, PH-MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the EQR PIP cycle for all PH-MCOs in 2022, PH-MCOs were required to report on two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: "Preventing Inappropriate Use or Overuse of Opioids" and "Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits."

"Preventing Inappropriate Use or Overuse of Opioids" was selected in light of the growing epidemic of accidental drug overdose in the United States, which is currently the leading cause of death in those under 50 years old living in the United States. In light of this, governmental regulatory agencies have released multiple regulatory measures and societal recommendations in an effort to decrease the amount of opioid prescriptions. PA DHS has sought to implement these measures as quickly as possible to impact its at-risk populations. While these measures are new and there is currently little historical data on these measures as of 2021, it remains a priority that future trends are monitored. MCOs were encouraged to develop aim statements for this project that look at preventing overuse/overdose, promoting treatment options, and stigma-reducing initiatives. Since the HEDIS Risk of Continued Opioid Use (COU) and CMS Adult Core Set Concurrent Use of Opioids and Benzodiazepines (COB) measures were first-year measures in 2019, a comparison to the national average was not available at project implementation. However, in PA, Use of Opioids at High Dosage (HDO) was found to be better than the national average for 2019, while Use of Opioids from Multiple Providers (UOP) was worse. The HEDIS UOP measure was worse than the national average for all three indicators: four or more prescribers, four or more pharmacies, and four or more prescribers and pharmacies.

In addition to increased collection of national measures, DHS has implemented mechanisms to examine other issues related to opioid use disorder (OUD) and coordinated treatment. In 2016, the governor of PA implemented the Centers of Excellence (COE) for Opioid Use Disorder program. Prior to COE implementation, 48% of Medicaid enrollees received OUD treatment, whereas after one year of implementation, 71% received treatment. Additionally, the DHS Quality Care Hospital Assessment Initiative, which focuses on ensuring access to quality hospital services for Pennsylvania Medical Assistance (MA) beneficiaries, was

reauthorized in 2018 and included the addition of an Opioid Use Disorder (OUD) incentive. The incentive, based on follow up within 7 days for opioid treatment after a visit to the emergency department (ED) for opioid use disorder, allows hospitals the opportunity to earn incentives by implementing defined clinical pathways to help them get more individuals with OUD into treatment. The DHS also worked with the University of Pittsburgh to analyze OUD treatment, particularly MAT, for PA Medicaid enrollees. Among the findings presented in January 2021 were that the number of Medicaid enrollees receiving medication for OUD more than doubled from 2014-2018, and that the increase was driven by office-based prescriptions for buprenorphine or naltrexone, was seen for nearly all demographic sub-groups, and was higher for rural areas. Similarly, under the Drug and Treatment Act (DATA), prescription rates for buprenorphine have increased. This act allows qualifying practitioners to prescribe buprenorphine for OUD treatment from 30 up to 275 patients and is another component of DHS' continuum of care.

Because opioid misuse and abuse is a national crisis, and due to the impact this has had particularly on PA, the new PH PIP is centered on opioids within the following four common outcome objectives: opioid prevention, harm reduction, coordination/facilitation into treatment, and increase medicated-assisted treatment (MAT) utilization. For this PIP, the four outcome measures discussed above will be collected and in consideration of the initiatives already implemented in PA, three process-oriented measures related to these initiatives will also be collected, focusing on the percentage of individuals with OUD who get into MAT, the duration of treatment for those that get into MAT, and follow-up after an emergency department (ED) visit for OUD. MCOs will define these three measures for their PIPs.

For this PIP, OMAP has required all PH MCOs to submit the following measures on an annual basis:

- Use of Opioids at High Dosage (HDO – HEDIS)
- Use of Opioids from Multiple Providers (UOP – HEDIS)
- Risk of Continued Opioid Use (COU – HEDIS)
- Concurrent Use of Opioids and Benzodiazepines (COB – CMS Adult Core Set)
- Percent of Individuals with OUD who receive MAT (MCO-defined)
- Percentage of adults > 18 years with pharmacotherapy for OUD who have (MCO-defined):
    - at least 90 and;
    - 180 days of continuous treatment
- Follow-up treatment within 7 days after ED visit for Opioid Use Disorder (MCO-defined)

Additionally, MCOs are expected to expand efforts to address health disparities in their populations. MCOs were instructed to identify race and ethnicity barriers and identify interventions that will be implemented to remediate the barriers identified.

"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits" was selected again due to several factors. General findings and recommendations from the PA Rethinking Care Program (RCP) – Serious Mental Illness (SMI) Innovation Project (RCP-SMI) and Joint PH/BH Readmission projects, as well as overall statewide readmission rates and results from several applicable HEDIS and PA Performance Measures across multiple years have highlighted this topic as an area of concern to be addressed for improvement. For the recently completed Readmissions PIP, several performance measures targeted at examining preventable hospitalizations and ED visits were collected, including measures collected as part of the PH-MCO and BH-MCO Integrated Care Plan (ICP) Program Pay for Performance Program, which was implemented in 2016 to address the needs of individuals with serious persistent mental illness (SPMI). From PIP reporting years 2016 to 2019, results varied across measures and MCOs. Additionally, from 2017 to 2019, the ICP performance measures targeting the SPMI population showed inconsistent trends and little to no improvement in reducing hospitalizations and ED visits.

Research continues to indicate multiple factors that can contribute to preventable admissions and readmissions as well as the link between readmissions and mental illness. Additionally, within PA, there are existing initiatives that lend themselves to integration of care and targeting preventable hospitalizations and can potentially be leveraged for applicable interventions. The Patient-Centered Medical Home (PCMH) model of patient care, which focuses on the whole person, taking both the individual's PH and BH into account, has been added to the HealthChoices Agreement. The DHS Quality Care Hospital Assessment Initiative focuses on ensuring access to quality hospital services for PA MA beneficiaries. Under this initiative, the Hospital Quality Incentive Program (HQIP) builds off of existing DHS programs: MCO P4P, Provider P4P within HealthChoices PH, and the ICP Program. It focuses on preventable admissions and provides incentives for annual improvement or against a state benchmark.

Given the PA DHS initiatives that focus on coordination and integration of services and the inconsistent improvement on several metrics, it has become apparent that continued intervention in this area of healthcare for the HealthChoices population is warranted. MCOs were encouraged to develop aim statements for this project that look at reducing potentially avoidable ED visits and hospitalizations, including admissions that are avoidable initial admissions and readmissions that are potentially preventable.

For this PIP, OMAP has required all PH MCOs to submit the following core measures on an annual basis:

- Ambulatory Care (AMB): ED Utilization (HEDIS)
- Inpatient Utilization—General Hospital/Acute Care (IPU): Total Discharges (HEDIS)
- Plan All-Cause Readmissions (PCR – HEDIS)
- PH MCOs were given the criteria used to define the SPMI population, and will be collecting each of the following ICP measures using data from their own systems:
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (MCO Defined)
    - Emergency Room Utilization for Individuals with SPMI (MCO Defined)
    - Inpatient Admission Utilization for Individuals with SPMI (MCO Defined)
    - Adherence to Antipsychotic Medications for Individual with Schizophrenia (MCO Defined)
    - Inpatient 30-Day Readmission Rate for Individuals with SPMI (MCO Defined)

Additionally, MCOs are expected to expand efforts to address health disparities in their populations. MCOs were instructed to identify race/ethnicity barriers and identify interventions that will be implemented to remediate the barriers identified.

These PIPs will extend from January 2019 through December 2022. With research beginning in 2019, initial PIP proposals were developed and submitted in third quarter 2021, a final report will be due in October 2023. The non-intervention baseline period was January 2019 to December 2019. Following the formal PIP proposal, the timeline defined for the PIPs includes interim reports in October 2021 and October 2022, as well as a final report in October 2023. For the current review year, 2022, interim reports were due in October. These interim reports underwent initial review by IPRO, and feedback was provided to plans, with a timeline to resubmit to address areas of concern.

The 2022 EQR is the nineteenth year to include validation of PIPs. For each PIP, all PH MCOs shared the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions, and timeliness.

As part of the new EQR PIP cycle that was initiated for all Medicaid MCOs in 2020, IPRO adopted the Lean methodology, following the CMS recommendation that QIOs and other healthcare stakeholders embrace Lean in order to promote continuous quality improvement in healthcare.

All PH MCOs were required to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology,
- Data/Results,
- Analysis Cycle, and
- Interventions.

To encourage MCOs to focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the PH-MCOs, and IPRO continued and progressed throughout the review year. **Tables 1a** and **1b** summarize PIP compliance assessments across MCOs.

Table 1a: PH-MCO PIP Review Score – Preventing Inappropriate Use or Overuse of Opioids

Project 1 - Preventing Inappropriate Use or Overuse of Opioids	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic	C	P	P	P	C	P	C	C	P
2. Methodology	C	P	C	C	C	P	C	C	P
3. Barrier Analysis, Interventions, and Monitoring	C	P	P	P	P	P	P	P	P
4. Results	C	P	P	C	P	P	C	C	P
5. Discussion	C	P	NC	C	P	P	P	C	P
6. Next Steps	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7. Validity and Reliability of PIP Results	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 1b: PH-MCO PIP Review Score – Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits

Project 2 - Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic	C	P	P	C	C	P	C	C	P
2. Methodology	C	P	P	C	C	P	P	C	P
3. Barrier Analysis, Interventions, and Monitoring	C	P	P	C	C	P	P	P	P
4. Results	C	P	P	C	C	P	P	C	P
5. Discussion	C	P	NC	C	C	P	C	P	P
6. Next Steps	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7. Validity and Reliability of PIP Results	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

CHIP-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each CHIP MCO. For the purposes of the EQR, CHIP MCOs were required to participate in studies selected by DHS CHIP for validation by IPRO in 2022 for 2021 activities. Under the applicable Agreement with DHS in effect during this review period, CHIP MCOs are required to conduct focused studies each year. For all CHIP MCOs, two new PIPs were initiated as part of this requirement in 2022. For all PIPs, CHIP MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the EQR PIP cycle that was initiated for all CHIP MCOs in 2022, CHIP MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, the two topics selected were "Improving Access to Pediatric Preventive Dental Care" and "Improving Blood Lead Screening Rate in Children."

"Improving Access to Pediatric Preventive Dental Care" was selected after review showed that several dental metrics have consistently fallen below comparable populations or have not steadily improved across years. For the HEDIS® Annual Dental Visit (ADV) measure, while CHIP Managed Care averages have been higher than Medicaid Managed Care averages for most age cohorts since 2015, the CHIP averages have been consistently lower than Medicaid for the youngest cohort (ages 2-3) during the same time period. Additionally, from HEDIS 2018 to HEDIS 2020, year-to-year trends in CHIP averages across age cohorts have fluctuated, with no steady improvement for any age cohort. Preventive dental measures also indicated room for improvement. Prior to CMS' replacement of the Dental Sealants In 6–9-Year-Old Children at Elevated Caries Risk measure for MY 2020, CHIP rates varied from roughly 19% to roughly 25% since 2015. At the time of topic development, trends were not available for the new CMS sealant measure, Sealant Receipt on Permanent 1st Molars (SFM-CH), but MCOs have been encouraged to target this measure for examination. Further, CMS reporting of Federal Fiscal Year (FFY) 2014 data from the CMS-416 Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report followed trends from previous years, indicating that the percentage of Pennsylvania children aged 1-20 who received any preventive dental service for FFY 2014 (42.5%), was below the National rate of 45.6%.

Given the research that early childhood caries can lead to the presence of many poor health factors and that early preventive dental visits are effective in reducing the need of restorative and emergency care, it became apparent that examination of this research and how it might be applicable to CHIP is warranted, particularly given that metrics indicate there is room for improvement.

For this PIP, DHS CHIP is requiring all CHIP MCOs to submit the following measures on an annual basis:

- Annual Dental Visits (ADV – HEDIS). MCOs will report on the measure collected and submitted for HEDIS.
- Total Eligible Members Receiving Preventive Dental Services. For this measure, each MCO will define all parameters that will be used to collect and report a rate for this measure using its claims system.
- MCO-defined. Each MCO is required to identify and define at least one additional topic-related performance measure to collect and study for this PIP based on the data for its population.

"Improving Blood Lead Screening Rates in Children" was selected again due to several factors. A 2021 look at national trends regarding lead screening and blood lead levels (BLLs)showed that Pennsylvania was among the states with the highest number of children with elevated BLLs, with most samples coming from the Philadelphia and Pittsburgh metropolitan areas.[2] The National Surveillance Data table, utilizing NHANES data, supported this finding, citing percentages ranging from 6 to 9% for children with BLLs at least 5 ug/dL, and around 1.5% for children with at least 10 ug/dL in Pennsylvania.[3] Current CHIP policy requires that all children ages one and two years old and all children ages 3 through 6 years without a prior lead blood test have blood levels screened consistent with current Department of Health and CDC standards. Between 2012 and 2018, Pennsylvania has seen fluctuating lead screening rates for children younger than 72 months old, with 17.8% screened in both 2012 and again in 2018. Using the HEDIS Lead Screening measure, the average national lead screening rate in 2019 was 70.0%, while the Pennsylvania CHIP average was 66.2%. This rate fell between the 25th and 33rd percentile for HEDIS® Quality Compass benchmarks. Despite an overall improvement in lead screening rates for Pennsylvania CHIP Contractors over the previous few years, rates for MCO and weighted averages continued to be below the national average. Additionally, when comparing Pennsylvania Medicaid and CHIP rates, Medicaid's weighted average rate for 2019 was 81.6%, 15.5 points higher than CHIP. However, regarding population, it was noted that children less than 1 year of age typically receive Medicaid benefits until they reach one year. At this point, many children move over to CHIP, provided their families are eligible. MCOs were advised that this can affect overall CHIP rates across all MCOs, since the <1 year age group will have disproportionately fewer members than older age groups.

Given the inconsistent improvement and rates that continue to fall below national averages, DHS CHIP determined that it has become apparent that continued intervention in this area of healthcare for the CHIP population is necessary.

For this PIP, DHS CHIP is requiring all CHIP MCOs to submit the following measures on an annual basis:

- Lead Screening in Children (LSC – HEDIS). MCOs will report on the measure collected and submitted for HEDIS.
- Total Number of Children Successfully Identified with Elevated Blood Lead Levels. For this measure, each MCO will define all parameters that will be used to collect and report a rate for this measure using its claims system.
- MCO-defined. Each MCO is required to identify and define at least one additional topic-related performance measure to collect and study for this PIP based on the data for its population.

The PIPs extend from January 2021 through December 2024. The non-intervention baseline period is January 2021 to December 2021, with research beginning in 2022. Initial PIP proposals were developed and submitted in first quarter 2022, and baseline reports including any proposal updates were submitted by MCOs in

August 2022. Following the formal PIP proposal and baseline measurement reports, the timeline defined for the PIPs includes an interim report in 2023, as well as a final report in August 2024.

For each PIP, all CHIP MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS CHIP provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions and timeliness.

All CHIP MCOs are required to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology
- Data/Results
- Analysis Cycle
- Interventions

To encourage MCOs to focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the CHIP MCOs, and IPRO continued and progressed throughout the review year. **Tables 2a** and **2b** summarize PIP compliance assessments across MCOs.

Table 2a: CHIP-MCO PIP Review Score – Improving Access to Pediatric Preventive Dental Care

Project 1 - Improving Access to Pediatric Preventive Dental Care	**ABH**	**CBC**	**GEI**	**Highmark HMO**	**Highmark PPO**	**HPP**	**NEPA**	**IBC**	**UHC**	**UPMC**	**TOTAL CHIP MMC**
1. Project Topic and Rationale	C	P	P	C	C	C	C	C	P	C	P
2. Aim Statement	P	P	P	P	P	C	P	P	P	P	P
3. Methodology	C	P	P	P	P	P	P	P	C	C	P
4. Barrier Analysis	C	P	NC	P	P	C	P	P	P	C	P
5. Robust Interventions	P	P	P	P	P	C	P	P	P	C	P
6. Results Table	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7. Discussion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 2b: CHIP-MCO PIP Review Score – Improving Blood Lead Screening Rates in Children

Project 2 - Improving Blood Lead Screening Rates in Children	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	NEPA	IBC	UHC	UPMC	TOTALCHIP MMC
1. Project Topic and Rationale	C	P	P	C	C	C	P	C	P	C	P
2. Aim Statement	P	P	P	P	P	C	P	P	P	P	P
3. Methodology	P	P	P	P	P	P	P	P	P	P	P
4. Barrier Analysis	P	P	NC	P	P	P	NC	P	C	C	P
5. Robust Interventions	P	P	P	P	P	P	P	P	P	P	P
6. Results Table	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7. Discussion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

BH-MCO PIP Review

In 2019, OMHSAS directed IPRO to complete a preliminary study of substance use disorders (SUD) in the Commonwealth preliminary to selection of a new PIP topic. As a result, OMHSAS selected the topic, "Successful Prevention, Early Detection, Treatment, and Recovery for Substance Use Disorders" as a PIP for all BH-MCOs in the State. The PIP will extend from 2021 through 2023, including a final report due in 2024. While the topic is common to Primary Contractors and BH-MCOs, each project is developed as a collaboration and discussion between Primary Contractors and their contracted BH-MCOs. Primary Contractors and BH-MCOs were directed to begin conducting independent analyses of their data and partnering to develop relevant interventions and intervention tracking measures. BH-MCOs will be responsible for coordinating, implementing, and reporting the project.

The Aim Statement for this PIP is: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

OMHSAS selected three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an Opioid and/or other SUD;
2. Improve retention in treatment for members with an Opioid and/or other SUD diagnosis;
3. Increase concurrent use of Drug & Alcohol counseling in conjunction with Pharmacotherapy (Medication-Assisted Treatment); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH Contracting networks. The two "activities" may fall under a single intervention or may comprise two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP lens to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

Additionally, OMHSAS identified the following core performance indicators for the PEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[4] It contains two sub measures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure measures discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended here to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" includes detox episodes only.
3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure uses the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical stage. For this measure, "readmission" is defined as any acute inpatient admission with a primary MH diagnosis, as defined by the PA-specific FUH measure, occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.
4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[5] This measure is adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe Alcohol Use Disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD and targets members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

MCOs are expected to submit performance indicator results to IPRO on an annual basis. In addition to running as annual measures, quarterly rates will be used to enable measurement on a frequency that will support continuous monitoring and adjustment by the MCOs and their Primary Contractors.

The MCOs were required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with CMS protocols. These protocols follow a longitudinal format and capture information relating to:

- Project Topic/Rationale
- Aim
- Methodology
- Barrier Analysis
- Robust Interventions
- Results
- Discussion and Validity of Reported Improvement
- Sustainability

MCOs submitted initial proposals in September 2020 using an initial baseline period for the five performance indicators of July 1, 2019, through June 30, 2020. MCOs. All five MCO proposals underwent several review iterations and were finally approved for implementation by the first quarter of 2021. In 2021, the PIP project was renamed with the support of the BH-MCOs and Primary Contractors to be, "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders" in accordance with feedback received by the BH-MCOs and Primary Contractors during the first year of the PIP.

In order to establish a calendar year cycle, MCOs were required to recalculate baselines using the full CY 2020 and recalibrate PIP interventions accordingly. Proposals were successfully resubmitted in September 2021. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

CY 2021 marked Year 1 of the PIP. Year 1 reports were submitted in September 2022. **Table 3** summarizes the findings of the review of the Year 1 reports.

Table 3: BH-MCO PIP Review Score – Successful Prevention, Early Detection, Treatment, and Recovery for Substance Use Disorders

PIP - Successful Prevention, Early Detection, Treatment, and Recovery for Substance Use Disorders	BHO	CBH	CCBH	MBH	PerformCare	TOTAL BH MMC
1. Project Topic/Rationale	C	C	C	C	C	C
2. Aim	C	C	C	C	P	P
3. Methodology	C	C	C	C	P	P
4. Barrier Analysis	C	C	C	C	C	C
5. Robust Interventions	P	P	C	C	P	P
6. Results	P	P	C	C	C	P
7. Discussion and Validity of Reported Improvement	P	P	C	P	C	P
8. Sustainability	N/A	N/A	N/A	N/A	N/A	N/A

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls is to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. MCOs will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, instead of two semiannual submissions, MCOs submit only one PIP interim report each September, when formal scoring is rendered.

CHC-MCO PIP Review

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each CHC-MCO. For the purposes of the EQR, CHC-MCOs were required to participate in studies selected by DHS OLTL for validation by IPRO in 2018 for 2021 activities. Under the applicable Agreement with DHS in effect during this review period, CHC-MCOs are required to conduct focused studies each year. For all CHC-MCOs, two new PIPs were initiated as part of this requirement in 2019. For all PIPs, CHC-MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the new EQR PIP cycle that was initiated for all CHC-MCOs in 2018, IPRO adopted the LEAN methodology, following the CMS recommendation that Quality Improvement Organizations (QIOs) and other healthcare stakeholders embrace Lean in order to promote continuous quality improvement in healthcare. MCOs were provided with the most current Lean PIP submission and validation templates at the initiation of the PIP.

For each PIP, all CHC-MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS CHC provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions, and timeliness.

The MCO is required to develop and implement two internal PIPs chosen by DHS. For the current EQR PIP cycle, the two topics selected for CHC were Strengthening Care Coordination (which is robustly clinical in nature) and Transition of Care from the NF to the Community.

"Strengthening Care Coordination" was selected as a topic following discussions with stakeholders and in collaboration with the EQRO. Each CHC-MCO was required to implement interventions and indicate performance on the topic of strengthening care coordination with assessment and improvement of outcomes of care rendered by the CHC-MCO. Between 2018 and 2021, CHC-MCOs submitted proposals for PIP expansion in sequence with CHC being phased in. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly. Subsequent to each proposal submission, baseline data in proposals was then updated as supplemental data became available. For this PIP, CHC-MCOs were required to submit rates at the baseline, interim, and final measurement years for transitions of care measures aligned with clinical care coordination, with indicators for notification of inpatient admission, receipt of discharge note, engagement after inpatient discharge, as well as a hospitalization follow-up indicator for seven-day follow up behavioral discharge. Additionally, indicators aligned with capabilities of information systems were developed and implemented to encompass transitional care planning and adjustments to improved notification of discharge.

"Transition of Care from the NF to the Community" was selected following discussions with stakeholders and in collaboration with the EQRO. Each CHC-MCO was required to implement interventions and indicate performance on the topic of transition of care from the nursing facility to the community, entailing assessment and improvement of outcomes of care rendered by the MCO. Between 2018 and 2021, CHC-MCOs submitted proposals for PIP expansion in sequence with CHC being phased in. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly. Subsequent to each proposal submission, baseline data in proposals was then updated as supplemental data became available. For this PIP, CHC-MCOs were required to submit rates at the baseline, interim, and final measurement years for transitions of care measures, with indicators for receipt of discharge note, engagement after inpatient

discharge, and medication reconciliation, and an indicator for remaining in home or community post-discharge. Additionally, an indicator aligned with capabilities of information systems was developed and implemented to encompass transitional care planning.

All CHC-MCOs are required to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology
- Data/Results
- Analysis Cycle
- Interventions

Under the LEAN methodology adopted for the new CHC-PIP cycle and utilizing the new LEAN templates developed for this process, IPRO evaluated each CHC-MCOs' PIPs with regard to the following standardized elements: Topic/Rationale (Element 1); Aim (Element 2); Methodology (Element 3); Barrier Analysis (Element 4); Robust Interventions (Element 5) Results (Element 6); Discussion and Validity of Reported Improvement (Element 7); and Sustainability (Element 8; as applicable).

The first six elements relate to the baseline and demonstrable improvement phases of the project. The seventh element relates to validity of reported improvement, and the eighth element relates to sustainability of this improvement. Each submitted PIP report is evaluated against the eight review elements and associated requirements. For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each applicable element carries a separate weight. Scoring for each applicable element is based on assessment results of full, partial, and non-compliance. Points are awarded for the two phases of the PIP noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance, as described above under the Scoring Matrix subsection: if the element is designated as full compliance (defined as having met or exceeded the element requirements), the designation weight is 100%; if the element is designated as partial compliance (defined as having met essential requirements, but is deficient in some areas), the designation weight is 50%; if the element is designated as not in compliance (defined as having not met the essential requirements of the element), the designation weight is 0%.

Overall Performance Score

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. For the EQR PIPs, the review elements for demonstrable improvement have a total weight of 80%. For the current RY, the highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance; refer to **Table 4**). Untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into overall determinations.

Table 4: CHC PIP Review Element Scoring Weights (Scoring Matrix)

Review Element	Standard	Scoring Weight
1	Topic/rationale	5%
2	Aim	5%
3	Methodology	15%
4	Barrier analysis	15%
5	Robust interventions	15%
6	Results table	5%
7	Discussion and validity of reported improvement	20%
Total demonstrable improvement score		**80%**
8	Sustainability[1]	20%
Total sustained improvement score		**20%**
Overall project performance score		**100%**

[1] For the RY of this report, a determination for Element #8 (Sustainability) is not yet applicable based on the phase of CHC PIP implementation.

As also noted in Table 3 (Scoring Matrix), PIPs are also reviewed for the achievement of sustained improvement. For the EQR of CHC-MCO PIPs, sustained improvement elements have a total weight of 20%, for a possible maximum total of 20 points. The MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation by IPRO will occur at the end of the current PIP cycle. In 2022, a determination for Element #8 (Sustainability) is not yet applicable based on the phase of CHC PIP implementation.

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements for which activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. The same project will then be evaluated for other elements at a later date, according to the PIP submission schedule. Each element is scored. Elements that are met receive an evaluation score of 100%, elements that are partially met receive a score of 50%, and elements that are not met receive a score of 0%. Overall, for PIP implementation, compliance determinations are as follows: compliance is deemed met for scores ≥ 85%, partially met for scores 60–84%, and not met for scores < 60%. Corrective action plans are not warranted for CHC-MCOs that are compliant with PIP implementation requirements. At the discretion of OLTL, PIP proposals (including PIP expansion proposals) are approved for implementation; furthermore, untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into corrective action determinations.

PIP activities during the year included updating PIP performance indicator (PI) goals, baseline rates, barrier analyses, and development and implementation of interventions as well as additional PIs. For measurement in the PIP, multiple data sources were allowable, including: MCO pharmacies, service coordinator entities, copayments (i.e., after day 20 for Medicare-covered skilled nursing stays), and traditional long-term care claims. Preliminary measurements were based on participants that were Medicaid-only CHC participants and/or aligned D-SNP CHC participants; as PIP implementation expanded, CHC-MCOs utilized internal claims while the supplemental data source integration was scaled accordingly. Baseline rates were recalculated (and integrated into the PIP) with improved access to data. Annual PIP reports on Year 2 Implementation, which were subjected to EQR and scored for reporting the year's PIP compliance determinations, were submitted to the EQRO in March 2022 with updates on interventions through the first half of 2022 due to the EQRO in July 2022.

Tables 5a and **5b** summarize PIP compliance assessments across CHC-MCOs for Annual PIP Reports (Year 2 Implementation) review findings. The multiple levels of activity and collaboration between DHS, the CHC-MCOs, and IPRO continued and progressed throughout the review year.

Table 5a: CHC-MCO PIP Review Score – Strengthening Care Coordination

Project 1 - Strengthening Care Coordination	ACP CHC[1]	KF CHC[1]	PAHW	UPMC CHC	TOTAL CHC MMC
1. Project Topic and Rationale	C	C	C	C	C
2. Aim Statement	C	C	C	C	C
3. Methodology	C	C	C	C	C
4. Barrier Analysis	C	C	C	C	C
5. Robust Interventions	C	C	C	C	C
6. Results Table	C	C	C	C	C
7. Discussion	C	C	C	C	C
8. Sustainability	N/A	N/A	N/A	N/A	N/A

[1] For the July 2022 PIP Update, PIP submissions for ACP CHC/KF CHC were not submitted in accordance with the submission schedule. Timely submission is required per the CHC Agreement (Exhibit W "External Quality Review"). Timely submission is required for purposes of validation by the EQRO. Consequently, and in discussion with the Department, ACP CHC/KF CHC received overall determinations of partial compliance on PIPs.

Table 5b: CHC-MCO PIP Review Score – Transition of Care from the NF to the Community

Project 2 - Transition of Care from the NF to the Community	ACP CHC[1]	KF CHC[1]	PAHW	UPMC CHC	TOTAL CHC MMC
1. Project Topic and Rationale	C	C	C	C	C
2. Aim Statement	C	C	C	C	C
3. Methodology	C	C	C	C	C
4. Barrier Analysis	C	C	C	C	C
5. Robust Interventions	P	P	C	C	P
6. Results Table	C	C	C	C	C
7. Discussion	C	C	C	C	C
8. Sustainability	N/A	N/A	N/A	N/A	N/A

[1] For the July 2022 PIP Update, PIP submissions for ACP CHC/KF CHC were not submitted in accordance with the submission schedule. Timely submission is required per the CHC Agreement (Exhibit W "External Quality Review"). Timely submission is required for purposes of validation by the EQRO. Consequently, and in discussion with the Department, ACP CHC/KF CHC received overall determinations of partial compliance on PIPs.

- Overall: compliance determinations for elements of Project Topic and Rationale, Aim Statement, Methodology, Barrier Analysis, Results Table, and Discussion were sufficiently met for both PIP topics; however, compliance determinations for elements of Robust Interventions were partially met for the Transitions of Care from NF to the Community PIP for ACP/KF.
- For each CHC-MCOs' two PIPs, all scores based on the element determinations exceeded ≥ 85%.
- ACP CHC/KF CHC were found to have a continued issue with timely reporting per the submission schedule.

It is recommended that ACP CHC/KF CHC address the above performance improvement project issue and submit all PIP reports timely per the submission schedule.

Section II: Performance Measures

The BBA requires that performance measures be validated in a manner consistent with the EQR protocol, *Validating Performance Measures*. Audits of MCOs are to be conducted as prescribed in NCQA's *HEDIS MY 2021, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures* and are consistent with the validation method described in the EQRO protocols.

PH-MCO Performance Measures

Each PH-MCO underwent a full HEDIS Compliance Audit in 2022. The PH-MCOs are required by DHS, as part of their Quality Assessment and Performance Improvement (QAPI) programs, to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the *HEDIS MY 2021: Volume 2: Technical Specifications*. All the PH-MCO HEDIS rates are compiled and provided to DHS on an annual basis. **Table 6a** represents the HEDIS performance for all eight PH-MCOs in 2022, as well as the PH MMC mean and the PH MMC weighted average. If the denominator was less than 30 for a particular rate, "N/A" (Not Applicable) appears in the corresponding cells. The arrows indicate improvement (▲) or decline (▼) in the weighted average from the previous year.

Comparisons to fee-for-service Medicaid data are not included in this report as the fee-for-service data and processes were not subject to a HEDIS compliance audit for HEDIS MY 2021 measures.

Table 6a is the full set of HEDIS MY 2021 measures reported to OMAP. The individual MCO 2022 (MY 2021) EQR reports include a subset of these measures.

Table 6a: PH-MCO Results for 2022 (MY 2021) HEDIS Measures

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
Effectiveness of Care											
Prevention and Screening											
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC) – Hybrid											
WCC: BMI Percentile Ages 3 - 11 years	83.73%	84.02%	81.62%	90.64%	86.31%	82.68%	90.51%	78.23%	84.72%	83.90%	▲
WCC: BMI Percentile Ages 12 - 17 years	79.25%	87.50%	74.67%	87.79%	85.14%	80.71%	86.86%	74.31%	82.03%	81.55%	▲
WCC: BMI Percentile Total	82.00%	85.57%	78.51%	89.62%	85.89%	81.94%	89.29%	76.79%	83.70%	83.02%	▲
WCC: Counseling for Nutrition Ages 3 - 11 years	79.76%	79.45%	78.38%	82.55%	81.37%	76.62%	84.31%	70.97%	79.18%	78.16%	▲
WCC: Counseling for Nutrition Ages 12 - 17 years	69.18%	80.68%	66.67%	75.57%	76.35%	77.14%	81.02%	66.67%	74.16%	74.20%	▲

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
WCC: Counseling for Nutrition Total	75.67%	80.00%	73.13%	80.05%	79.56%	76.82%	83.21%	69.39%	77.23%	76.62%	▲
WCC: Counseling for Physical Activity Ages 3 - 11 years	76.98%	73.06%	73.51%	63.40%	78.33%	72.73%	79.93%	69.76%	73.46%	72.97%	▲
WCC: Counseling for Physical Activity Ages 12 - 17 years	71.07%	81.25%	68.00%	70.23%	77.70%	77.14%	79.56%	67.36%	74.04%	74.19%	▲
WCC: Counseling for Physical Activity Ages Total	74.70%	76.71%	71.04%	65.85%	78.10%	74.39%	79.81%	68.88%	73.69%	73.45%	▲
Childhood Immunization Status (CIS) – Hybrid											
CIS: DTaP/DT	73.48%	73.72%	72.26%	72.26%	72.99%	75.43%	70.80%	79.56%	73.81%	74.49%	▼
CIS: IPV	89.54%	89.05%	91.24%	87.83%	88.32%	89.78%	84.91%	93.19%	89.23%	89.61%	▼
CIS: MMR	88.08%	84.91%	87.59%	85.40%	88.81%	85.89%	81.27%	90.02%	86.50%	86.76%	▼
CIS: HiB	86.86%	84.18%	83.45%	86.86%	88.81%	88.81%	84.43%	92.46%	86.98%	87.65%	▼
CIS: Hepatitis B	90.51%	90.75%	92.46%	90.27%	89.54%	91.73%	89.29%	93.43%	91.00%	91.24%	▼
CIS: VZV	86.86%	85.64%	87.35%	84.67%	88.08%	85.89%	81.27%	90.02%	86.22%	86.56%	▼
CIS: Pneumococcal Conjugate	75.43%	74.45%	76.89%	74.70%	75.67%	78.35%	72.02%	80.78%	76.04%	76.64%	▼
CIS: Hepatitis A	85.64%	82.00%	81.27%	83.94%	83.45%	83.70%	78.83%	87.83%	83.33%	83.76%	▼
CIS: Rotavirus	72.02%	70.07%	73.48%	64.72%	69.83%	77.13%	70.32%	74.70%	71.53%	72.23%	▼
CIS: Influenza	52.31%	47.93%	47.45%	50.12%	48.66%	55.72%	52.07%	49.88%	50.52%	50.84%	▼
CIS: Combination 3	67.64%	69.59%	66.67%	68.61%	66.91%	71.29%	65.45%	72.99%	68.64%	69.32%	▼
CIS: Combination 7	59.37%	58.15%	56.93%	54.26%	56.93%	62.29%	56.20%	62.53%	58.33%	59.05%	▼
CIS: Combination 10	41.12%	35.77%	35.52%	36.98%	36.50%	45.74%	39.66%	38.44%	38.72%	39.23%	▼
Immunizations for Adolescents (IMA) – Hybrid											
IMA: Meningococcal	82.24%	87.83%	83.94%	84.91%	90.75%	84.94%	82.48%	86.86%	85.49%	85.85%	▼
IMA: Tdap/Td	81.75%	88.56%	84.67%	86.37%	90.51%	85.37%	83.45%	87.10%	85.97%	86.32%	▼
IMA: HPV	34.79%	41.12%	33.09%	50.12%	42.34%	40.54%	39.17%	39.42%	40.07%	40.41%	▼
IMA: Combination 1	80.54%	86.86%	82.48%	84.67%	89.78%	83.69%	81.75%	85.64%	84.43%	84.78%	▼
IMA: Combination 2	33.33%	40.15%	32.36%	49.39%	41.61%	39.49%	37.23%	37.96%	38.94%	39.29%	▼
Lead Screening in Children (LSC) – Hybrid											
LSC: Rate	79.08%	78.94%	84.43%	79.63%	83.45%	80.89%	77.10%	86.13%	81.21%	81.60%	▼

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
Breast Cancer Screening (BCS) – Administrative											
BCS: Rate	42.01%	55.57%	55.34%	51.67%	48.83%	49.59%	47.72%	51.94%	50.33%	50.90%	▼
Cervical Cancer Screening (CCS)[1] – Hybrid											
CCS: Rate	53.04%	61.73%	55.41%	57.55%	59.85%	65.69%	56.69%	64.76%	59.34%	60.51%	▼
Chlamydia Screening in Women (CHL) – Administrative											
CHL: Ages 16 - 20 years	47.41%	47.56%	46.14%	68.64%	50.66%	62.86%	51.51%	48.26%	52.88%	53.17%	▼
CHL: Ages 21 - 24 years	57.14%	57.41%	57.14%	71.92%	59.10%	69.44%	61.33%	55.81%	61.16%	61.36%	▲
CHL: Total Rate	52.42%	52.16%	51.17%	70.29%	54.49%	65.87%	56.18%	51.76%	56.79%	57.02%	▲
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) – Administrative											
NCS: Rate	0.21%	0.24%	0.90%	0.22%	0.27%	0.15%	0.21%	0.49%	0.34%	0.33%	▼
Respiratory Conditions											
Appropriate Testing for Pharyngitis (CWP) – Administrative											
CWP: Ages 3 - 17 years	70.83%	67.56%	73.46%	68.28%	74.49%	72.92%	77.35%	78.58%	72.93%	73.72%	▼
CWP: Ages 18 - 64 years	50.29%	51.11%	56.34%	35.40%	55.68%	36.93%	57.43%	60.46%	50.46%	51.89%	▼
CWP: Ages 65+ years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CWP: Total Rate	59.30%	59.34%	65.41%	47.00%	64.97%	51.40%	66.57%	69.31%	60.41%	62.14%	▼
Appropriate Treatment for Upper Respiratory Infection (URI) – Administrative											
URI: Ages 3 months - 17 years	95.13%	95.02%	93.36%	97.73%	95.92%	97.60%	96.23%	95.23%	95.78%	95.66%	▲
URI: Ages 18 - 64 years	85.52%	86.99%	82.94%	82.10%	89.39%	79.66%	87.23%	86.03%	84.98%	85.53%	▲
URI: Ages 65+ years	N/A	N/A	N/A	N/A	N/A	89.36%	N/A	N/A	89.36%	89.36%	▲
URI: Total Rate	92.12%	92.31%	89.90%	93.26%	93.77%	93.23%	93.18%	91.97%	92.47%	92.38%	▲
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Administrative											
AAB: Ages 3 months - 17 years	77.23%	69.04%	66.15%	90.97%	66.77%	90.72%	84.02%	72.35%	77.16%	76.09%	▲
AAB: Ages 18 - 64 years	51.22%	45.60%	49.33%	59.81%	52.19%	51.42%	46.64%	47.31%	50.44%	49.49%	▲
AAB: Ages 65+ years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
AAB: Total Rate	61.48%	55.45%	54.97%	71.03%	58.40%	73.01%	61.40%	55.67%	61.43%	60.03%	▼
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) – Administrative											
SPR: Rate	26.09%	26.22%	25.32%	22.17%	24.41%	20.62%	21.56%	25.87%	24.03%	24.17%	▼
Pharmacotherapy Management of COPD Exacerbation (PCE) – Administrative											
PCE: Systemic Corticosteroid	87.57%	77.59%	81.50%	75.00%	74.61%	73.01%	72.35%	81.76%	77.92%	77.97%	▲
PCE: Bronchodilator	92.14%	85.91%	87.60%	88.40%	85.55%	88.27%	83.66%	86.78%	87.29%	87.20%	▼

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
Asthma Medication Ratio (AMR) – Administrative											
AMR: Ages 5 - 11 years	75.77%	82.19%	84.65%	75.46%	78.04%	75.52%	73.13%	80.51%	78.16%	77.56%	▼
AMR: Ages 12 - 18 years	65.45%	74.71%	76.37%	73.15%	68.74%	74.41%	66.94%	72.10%	71.48%	72.39%	▲
AMR: Ages 19 - 50 years	57.29%	59.48%	56.89%	61.55%	58.49%	59.07%	54.85%	62.20%	58.73%	59.25%	▲
AMR: Ages 51 - 64 years	59.62%	60.17%	55.44%	61.94%	60.84%	58.08%	57.66%	63.15%	59.61%	59.95%	▲
AMR: Total Rate	62.60%	66.07%	64.15%	66.53%	64.02%	66.57%	61.47%	67.07%	64.81%	65.43%	▲
Cardiovascular Conditions											
Controlling High Blood Pressure (CBP) – Hybrid											
CBP: Total Rate	62.77%	68.61%	67.64%	64.96%	69.10%	55.47%	62.77%	69.83%	65.14%	65.22%	▲
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) – Administrative											
PBH: Rate	80.77%	82.63%	91.41%	87.23%	87.65%	83.17%	90.24%	89.15%	86.53%	86.55%	▲
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Administrative											
SPC: Received Statin Therapy - Ages 21-75 years (Male)	82.38%	86.74%	85.98%	87.77%	84.15%	84.77%	79.57%	84.79%	84.52%	84.74%	▲
SPC: Received Statin Therapy - Ages 40-75 years (Female)	85.31%	86.20%	86.48%	82.97%	84.49%	78.38%	82.54%	82.99%	83.67%	83.48%	▲
SPC: Received Statin Therapy - Total Rate	83.35%	86.50%	86.19%	85.91%	84.30%	82.48%	80.73%	84.06%	84.19%	84.24%	▲
SPC: Statin Adherence 80% - Ages 21-75 years (Male)	74.00%	77.27%	77.44%	68.71%	73.47%	77.59%	76.07%	76.06%	75.08%	75.35%	▼
SPC: Statin Adherence 80% - Ages 40-75 years (Female)	77.05%	77.40%	75.95%	71.36%	74.00%	78.54%	74.78%	76.72%	75.73%	75.92%	▼
SPC: Statin Adherence 80% - Total Rate	75.03%	77.33%	76.81%	69.70%	73.70%	77.92%	75.55%	76.32%	75.30%	75.57%	▼
Cardiac Rehabilitation (CRE) – Administrative											
CRE: Initiation - 2 or more sessions within 30 days (Ages 18-64)	3.24%	3.67%	2.54%	1.80%	1.59%	1.33%	2.17%	1.75%	2.26%	2.14%	▲

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
CRE: Initiation - 2 or more sessions within 30 days (Ages 65+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CRE: Initiation - 2 or more sessions within 30 days (Total)	3.19%	3.64%	2.53%	1.78%	1.58%	1.59%	2.14%	1.74%	2.27%	2.16%	▲
CRE: Engagement 1 - 12 or more sessions within 90 days (Ages 18-64)	3.74%	4.25%	3.46%	2.20%	0.00%	2.36%	2.56%	2.95%	2.69%	2.68%	▼
CRE: Engagement 1 - 12 or more sessions within 90 days (Ages 65+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CRE: Engagement 1 - 12 or more sessions within 90 days (Total)	3.69%	4.21%	3.46%	2.18%	0.00%	2.75%	2.53%	3.01%	2.73%	2.74%	▲
CRE: Engagement 2 - 24 or more sessions within 180 days (Ages 18-64)	3.49%	2.90%	2.54%	2.81%	0.00%	1.47%	2.56%	1.84%	2.20%	2.10%	▼
CRE: Engagement 2 - 24 or more sessions within 180 days (Ages 65+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CRE: Engagement 2 - 24 or more sessions within 180 days (Total)	3.44%	2.87%	2.53%	2.77%	0.00%	1.88%	2.53%	1.92%	2.24%	2.16%	▼
CRE: Achievement - 36 or more sessions within 180 days (Ages 18-64)	1.25%	0.19%	0.69%	0.20%	0.00%	0.00%	0.39%	0.46%	0.40%	0.37%	▼
CRE: Achievement - 36 or more sessions within 180 days (Ages 65+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
CRE: Achievement - 36 or more sessions within 180 days (Total)	1.23%	0.19%	0.69%	0.20%	0.00%	0.00%	0.39%	0.46%	0.40%	0.36%	▼
Diabetes											
Comprehensive Diabetes Care (CDC) – Hybrid											
CDC: HbA1c Testing	80.29%	84.91%	87.59%	86.37%	88.56%	80.54%	86.86%	86.62%	85.22%	85.23%	▲
CDC: HbA1c Poor Control (>9.0%)[2]	43.07%	35.77%	28.95%	34.31%	28.71%	42.09%	34.79%	37.96%	35.71%	36.05%	▼
CDC: HbA1c Control (<8.0%)	46.47%	53.28%	55.72%	55.47%	59.85%	51.09%	55.23%	54.26%	53.92%	54.07%	▲
CDC: Eye Exam	47.45%	52.80%	64.72%	50.36%	54.01%	53.77%	51.34%	61.07%	54.44%	55.19%	▲
CDC: Blood Pressure Controlled (<140/90 mm Hg)	66.67%	68.37%	78.59%	62.04%	70.80%	59.85%	66.18%	67.88%	67.55%	67.04%	▲
Statin Therapy for Patients With Diabetes (SPD) – Administrative											
SPD: Received Statin Therapy	68.26%	69.21%	68.61%	72.91%	69.80%	69.97%	68.95%	70.25%	69.75%	69.98%	▲
SPD: Statin Adherence 80%	73.07%	74.69%	73.96%	69.23%	72.38%	73.78%	71.01%	75.63%	72.97%	73.22%	▼
Kidney Health Evaluation for Patients with Diabetes (KED) – Administrative											
KED: Ages 18 - 64 years	39.41%	42.36%	43.18%	37.54%	40.07%	42.73%	42.10%	41.37%	41.10%	41.22%	▲
KED: Ages 65 - 74 years	53.33%	50.79%	60.75%	45.28%	53.07%	49.54%	49.77%	52.68%	51.90%	50.49%	▲
KED: Ages 75 - 85 years	57.14%	54.78%	64.10%	32.97%	44.44%	50.87%	43.40%	59.02%	50.84%	49.68%	▲
KED: Total Rate	39.80%	42.63%	43.46%	37.73%	40.30%	43.03%	42.30%	41.55%	41.35%	41.47%	▲
Musculoskeletal											
Use of Imaging Studies for Low Back Pain (LBP) – Administrative											
LBP: Rate	74.58%	73.13%	73.35%	82.07%	73.85%	80.95%	76.20%	77.50%	76.45%	76.57%	▼
Behavioral Health											
Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Administrative											
ADD: Initiation Phase	29.03%	43.19%	42.35%	44.68%	42.31%	35.68%	34.75%	48.51%	40.06%	41.23%	▼
ADD: Continuation and Maintenance Phase	34.98%	51.53%	44.26%	47.96%	50.22%	45.80%	42.14%	58.11%	46.88%	48.93%	▼
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) – Administrative											
SSD: Rate	88.99%	86.58%	88.88%	81.76%	87.54%	86.60%	86.66%	87.31%	86.79%	86.93%	▲

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) – Administrative											
SMD: Rate	65.91%	70.20%	82.81%	75.52%	68.66%	72.75%	62.68%	76.63%	71.90%	72.06%	▲
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) – Administrative											
SMC: Rate	N/A	77.42%	N/A	80.65%	N/A	68.57%	N/A	78.72%	76.34%	76.39%	▲
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) – Administrative											
SAA: Rate	50.98%	64.50%	64.21%	59.02%	64.05%	62.76%	53.71%	65.42%	60.58%	61.30%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) – Administrative											
APM: Blood Glucose Testing Ages 1 - 11 years	80.67%	68.96%	79.37%	43.33%	78.11%	63.81%	69.41%	75.44%	69.89%	72.87%	▲
APM: Blood Glucose Testing Ages 12 - 17 years	80.28%	79.49%	81.26%	59.11%	79.58%	70.34%	75.24%	78.98%	75.54%	77.42%	▲
APM: Blood Glucose Testing Total Rate	80.40%	76.14%	80.66%	54.90%	79.19%	68.64%	73.75%	77.93%	73.95%	76.11%	▲
APM: Cholesterol Testing Ages 1 - 11 years	70.59%	66.84%	74.22%	53.33%	75.12%	64.64%	65.30%	68.67%	67.34%	68.96%	▲
APM: Cholesterol Testing Ages 12 - 17 years	66.61%	66.06%	68.48%	63.16%	67.17%	61.66%	62.23%	65.02%	65.05%	65.31%	▲
APM: Cholesterol Testing Total Rate	67.79%	66.31%	70.31%	60.53%	69.25%	62.44%	63.01%	66.11%	65.72%	66.37%	▲
APM: Blood Glucose & Cholesterol Ages 1 - 11 years	69.33%	63.32%	71.52%	38.89%	71.14%	58.29%	63.01%	67.17%	62.83%	65.63%	▲
APM: Blood Glucose & Cholesterol Ages 12 - 17 years	65.36%	64.17%	67.23%	52.23%	65.76%	58.24%	60.82%	64.17%	62.25%	63.42%	▲
APM: Blood Glucose & Cholesterol Total Rate	66.54%	63.90%	68.59%	48.66%	67.17%	58.26%	61.38%	65.06%	62.45%	64.06%	▲
Pharmacotherapy for Opioid Use Disorder (POD) – Administrative											
POD: Ages 16 - 64 years	21.08%	27.33%	28.39%	18.73%	20.01%	21.60%	19.99%	21.93%	22.38%	22.12%	▼
POD: Ages 65+ years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
POD: Total Rate	21.06%	27.31%	28.43%	18.85%	20.00%	21.58%	19.97%	21.95%	22.39%	22.13%	▼
Antidepressant Medication Management (AMM)											
AMM: Effective Acute Phase Treatment	60.73%	64.21%	64.21%	55.33%	58.34%	60.91%	57.23%	63.32%	60.54%	61.19%	▲
AMM: Effective Continuation Phase Treatment	42.78%	47.07%	44.85%	38.99%	41.68%	44.34%	40.51%	45.38%	43.20%	43.79%	▲
Overuse/Appropriateness											
Risk of Continued Opioid Use (COU)[3] – Administrative											
COU: Ages 18-64 years - >=15 Days covered	3.60%	1.46%	2.58%	4.59%	3.61%	2.30%	2.18%	4.86%	3.15%	3.26%	▼
COU: Ages 65+ years - >=15 Days covered	15.63%	0.00%	N/A	14.75%	5.45%	0.85%	1.92%	15.87%	7.78%	6.57%	▲
COU: Total - >=15 Days covered	3.64%	1.46%	2.58%	4.65%	3.61%	2.29%	2.18%	4.89%	3.16%	3.27%	▼
COU: Ages 18-64 years - >=31 Days covered	1.44%	1.25%	1.51%	2.78%	2.16%	1.88%	1.70%	2.81%	1.94%	2.03%	▼
COU: Ages 65+ years - >=31 Days covered	3.13%	0.00%	N/A	9.84%	3.64%	0.85%	0.00%	3.17%	2.95%	2.72%	▼
COU: Total - >=31 Days covered	1.45%	1.25%	1.50%	2.82%	2.16%	1.88%	1.69%	2.81%	1.95%	2.04%	▼
Use of Opioids at High Dosage (HDO)[4] – Administrative											
HDO: Rate	7.28%	8.61%	7.85%	4.34%	6.58%	17.87%	9.11%	5.49%	8.39%	7.94%	▼
Use of Opioids From Multiple Providers (UOP)[5] – Administrative											
UOP: Rate receiving prescription opioids (4 or more prescribers)	20.03%	9.57%	11.47%	12.01%	13.34%	8.97%	17.02%	16.54%	13.62%	14.05%	▲
UOP: Rate receiving prescription opioids (4 or more pharmacies)	3.52%	0.76%	0.58%	1.02%	1.31%	1.43%	2.04%	0.84%	1.44%	1.21%	▼
UOP: Rate receiving prescription opioids (4 or more prescribers & pharmacies)	2.13%	0.50%	0.23%	0.60%	0.85%	0.63%	1.51%	0.49%	0.87%	0.71%	▲

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
Access/Availability of Care											
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Administrative											
AAP: Ages 20 - 44 years	65.98%	81.50%	81.57%	67.31%	78.60%	72.29%	71.84%	82.38%	75.18%	75.53%	▲
AAP: Ages 45 - 64 years	72.92%	86.80%	86.60%	78.42%	85.20%	81.01%	78.39%	87.58%	82.12%	82.81%	▼
AAP: Ages 65+ years	62.22%	80.34%	81.94%	74.78%	79.26%	75.45%	72.63%	81.10%	75.97%	75.74%	▲
AAP: Total Rate	67.87%	83.15%	83.14%	70.72%	80.61%	75.01%	73.75%	84.10%	77.29%	77.77%	▲
Annual Dental Visits (ADV) – Administrative											
ADV: Ages 2 - 3 years	36.34%	47.28%	41.49%	48.96%	52.35%	62.06%	47.52%	42.90%	47.36%	48.69%	▲
ADV: Ages 4 - 6 years	57.91%	67.94%	63.04%	64.94%	67.79%	74.92%	68.85%	64.18%	66.20%	67.10%	▲
ADV: Ages 7 - 10 years	61.25%	72.46%	68.21%	63.72%	70.14%	75.20%	71.48%	67.28%	68.72%	69.45%	▲
ADV: Ages 11 - 14 years	55.01%	69.23%	59.20%	58.82%	65.88%	72.91%	68.08%	62.28%	63.93%	65.15%	▲
ADV: Ages 15 - 18 years	45.79%	60.92%	48.72%	47.81%	57.32%	64.98%	59.07%	54.60%	54.90%	56.34%	▲
ADV: Ages 19 - 20 years	26.60%	45.07%	31.75%	30.50%	37.60%	47.71%	39.54%	38.81%	37.20%	38.58%	▲
ADV: Total Rate	50.45%	63.56%	55.20%	55.21%	61.40%	68.87%	62.02%	57.94%	59.33%	60.50%	▲
Prenatal and Postpartum Care (PPC) – Hybrid											
PPC: Timeliness of Prenatal Care	86.86%	89.54%	86.37%	90.75%	90.51%	87.83%	88.81%	90.02%	88.84%	88.97%	▲
PPC: Postpartum Care	73.48%	82.73%	80.05%	82.48%	77.62%	79.81%	79.81%	79.08%	79.38%	79.58%	▲
Utilization and Risk Adjusted Utilization											
Utilization											
Well-Child Visits in the First 30 Months of Life (W30) – Administrative											
W30: Well-Child Visits in the First 15 Months (6 or more visits)	60.07%	67.27%	65.24%	58.43%	69.18%	57.85%	65.36%	74.69%	64.76%	65.30%	▲
W30: Well-Child Visits for Age 15 Months - 30 Months (2 or more visits)	69.36%	72.90%	73.85%	64.75%	72.55%	68.98%	69.09%	78.09%	71.20%	71.63%	▼
Child and Adolescent Well-Care Visits (WCV) – Administrative											
WCV: 3 - 11 years	61.16%	65.49%	63.05%	65.79%	64.75%	67.63%	63.17%	66.96%	64.75%	65.33%	▲
WCV: 12 - 17 years	54.63%	59.73%	56.68%	60.38%	58.69%	62.70%	57.40%	61.21%	58.93%	59.63%	▲
WCV: 18 - 21 years	29.89%	36.00%	33.21%	34.74%	34.53%	38.15%	32.51%	39.48%	34.81%	35.56%	▲
WCV: Total Rate	53.74%	58.88%	55.56%	58.51%	57.54%	61.08%	55.54%	60.56%	57.68%	58.37%	▲

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average
Frequency of Selected Procedures (FSP) – Administrative										
FSP: Bariatric Weight Loss Surgery F Ages 0-19 Procs/1000 MM	0.00	0.02	0.01	0.01	0.00	0.00	0.01	0.01	0.01	
FSP: Bariatric Weight Loss Surgery F Ages 20-44 Procs/1000 MM	0.23	0.53	0.23	0.39	0.30	0.29	0.45	0.31	0.34	
FSP: Bariatric Weight Loss Surgery F Ages 45-64 Procs/1000 MM	0.15	0.37	0.26	0.23	0.23	0.20	0.24	0.25	0.24	
FSP: Bariatric Weight Loss Surgery M Ages 0-19 Procs/1000 MM	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.00	
FSP: Bariatric Weight Loss Surgery M Ages 20-44 Procs/1000 MM	0.02	0.12	0.03	0.05	0.05	0.03	0.07	0.05	0.05	
FSP: Bariatric Weight Loss Surgery M Ages 45-64 Procs/1000 MM	0.04	0.11	0.03	0.05	0.06	0.05	0.06	0.06	0.06	
FSP: Tonsillectomy MF Ages 0-9 Procs/1000 MM	0.25	0.33	0.25	0.21	0.28	0.22	0.19	0.34	0.26	
FSP: Tonsillectomy MF Ages 10-19 Procs/1000 MM	0.16	0.17	0.14	0.10	0.15	0.10	0.12	0.18	0.14	
FSP: Hysterectomy Abdominal F Ages 15-44 Procs/1000 MM	0.06	0.06	0.06	0.06	0.06	0.07	0.04	0.05	0.06	
FSP: Hysterectomy Abdominal F Ages 45-64 Procs/1000 MM	0.15	0.12	0.14	0.14	0.15	0.12	0.07	0.10	0.12	
FSP: Hysterectomy Vaginal F Ages 15-44 Procs/1000 MM	0.04	0.07	0.06	0.04	0.06	0.03	0.04	0.09	0.05	

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average
FSP: Hysterectomy Vaginal F Ages 45-64 Procs/1000 MM	0.09	0.08	0.05	0.11	0.11	0.08	0.05	0.11	0.09	
FSP: Cholecystectomy, Open M Ages 30-64 Procs/1000 MM	0.02	0.02	0.01	0.03	0.02	0.03	0.02	0.02	0.02	
FSP: Cholecystectomy, Open F Ages 15-44 Procs/1000 MM	0.01	0.01	0.00	0.01	0.01	0.01	0.01	0.01	0.01	
FSP: Cholecystectomy Open F Ages 45-64 Procs/1000 MM	0.02	0.02	0.02	0.03	0.03	0.03	0.02	0.02	0.02	
FSP: Cholecystectomy Closed M Ages 30-64 Procs/1000 MM	0.15	0.27	0.26	0.11	0.26	0.10	0.20	0.26	0.20	
FSP: Cholecystectomy Closed F Ages 15-44 Procs/1000 MM	0.47	0.62	0.64	0.30	0.51	0.30	0.42	0.60	0.48	
FSP: Cholecystectomy Closed F Ages 45-64 Procs/1000 MM	0.43	0.51	0.64	0.30	0.52	0.29	0.38	0.59	0.46	
FSP: Back Surgery M Ages 20-44 Procs/1000 MM	0.18	0.20	0.20	0.10	0.15	0.10	0.14	0.20	0.16	
FSP: Back Surgery F Ages 20-44 Procs/1000 MM	0.12	0.15	0.16	0.08	0.13	0.08	0.10	0.20	0.13	
FSP: Back Surgery M Ages 45-64 Procs/1000 MM	0.40	0.49	0.59	0.29	0.43	0.40	0.46	0.61	0.46	
FSP: Back Surgery F Ages 45-64 Procs/1000 MM	0.35	0.52	0.57	0.28	0.58	0.24	0.47	0.67	0.46	
FSP: Mastectomy F Ages 15-44 Procs/1000 MM	0.05	0.09	0.07	0.07	0.07	0.10	0.07	0.06	0.07	

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
FSP: Mastectomy F Ages 45-64 Procs/1000 MM	0.13	0.17	0.19	0.14	0.18	0.20	0.15	0.15	0.16		
FSP: Lumpectomy F Ages 15-44 Procs/1000 MM	0.10	0.12	0.09	0.09	0.11	0.10	0.09	0.09	0.10		
FSP: Lumpectomy F Ages 45-64 Procs/1000 MM	0.28	0.31	0.29	0.23	0.26	0.28	0.34	0.28	0.28		
Ambulatory Care: Total (AMBA) – Administrative											
AMBA: Outpatient Visits/1000 MM	259.71	382.63	363.88	259.02	337.78	267.66	296.29	407.88	321.86	325.72	▲
AMBA: Emergency Department Visits/1000 MM	48.78	56.52	47.26	48.32	55.65	46.95	49.04	52.32	50.61	50.69	▲
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA) – Administrative											
IPUA: Total Discharges/1000 MM	5.11	5.64	5.62	5.82	6.18	6.94	6.08	5.99	5.92		
IPUA: Medicine Discharges/1000 MM	2.37	2.62	2.86	2.76	3.01	3.84	3.06	2.60	2.89		
IPUA: Surgery Discharges/1000 MM	1.21	1.35	1.16	1.41	1.54	1.45	1.51	1.77	1.43		
IPUA: Maternity Discharges/1000 MM	2.00	2.29	2.12	2.16	2.21	2.27	1.98	2.17	2.15		
Antibiotic Utilization: Total (ABXA) – Administrative											
ABXA: Total # of Antibiotic Prescriptions M&F	143,807	194,934	164,739	130,677	174,156	235,803	135,703	365,569	193,174		
ABXA: Average # of Antibiotic Prescriptions PMPY M&F	0.64	0.65	0.76	0.49	0.63	0.54	0.56	0.83	0.64		
ABXA: Total Days Supplied for All Antibiotic Prescriptions M&F	1,201,896	1,855,801	1,640,373	1,170,179	1,673,974	2,177,489	1,294,372	3,286,465	1,787,569		

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average
ABXA: Average # Days Supplied per Antibiotic Prescription M&F	8.36	9.52	9.96	8.95	9.61	9.23	9.54	8.99	9.27	
ABXA: Total # of Prescriptions for Antibiotics of Concern M&F	52,591	66,760	64,487	37,693	58,517	71,552	44,685	137,042	66,666	
ABXA: Average # of Prescriptions for Antibiotics of Concern M&F	0.23	0.22	0.30	0.14	0.21	0.16	0.18	0.31	0.22	
ABXA: Percent Antibiotics of Concern of All Antibiotic Prescriptions	36.57%	34.25%	39.14%	28.84%	33.60%	30.34%	32.93%	37.49%	34.15%	
Risk Adjusted Utilization										
Plan All-Cause Readmissions (PCR) – Administrative										
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 18-44)	2,637	3,311	2,836	3,396	5,428	6,492	3,420	8,365	4,486	
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 45-54)	1,207	1,848	1,600	1,793	2,705	2,895	1,586	4,672	2,288	
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 55-64)	1,443	2,113	1,816	2,173	3,095	3,717	1,926	5,631	2,739	
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages Total)	5,287	7,272	6,252	7,362	11,228	13,104	6,932	18,668	9,513	
PCR: Count of Observed 30-Day	270	290	156	331	380	674	309	538	369	

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average
Readmissions - Total Stays (Ages 18-44)										
PCR: Count of Observed 30-Day Readmissions - Total Stays (Ages 45-54)	130	188	107	219	234	348	186	315	216	
PCR: Count of Observed 30-Day Readmissions - Total Stays (Ages 55-64)	182	238	155	228	319	447	215	467	281	
PCR: Count of Observed 30-Day Readmissions - Total Stays (Ages Total)	582	716	418	778	933	1,469	710	1,320	866	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages 18-44)	228.98	275.32	237.09	280.37	429.69	539.68	291.79	672.30	369.40	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages 45-54)	124.51	186.88	161.75	181.93	255.78	294.88	162.10	444.53	226.54	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages 55-64)	172.10	252.34	215.64	253.80	348.81	438.46	227.56	631.08	317.47	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages Total)	525.60	714.53	614.48	716.10	1,034.29	1,273.02	681.45	1,747.91	913.42	
PCR: Observed Readmission Rate - Total Stays (Ages 18-44)	10.24%	8.76%	5.50%	9.75%	7.00%	10.38%	9.04%	6.43%	8.39%	
PCR: Observed Readmission Rate -	10.77%	10.17%	6.69%	12.21%	8.65%	12.02%	11.73%	6.74%	9.87%	

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
Total Stays (Ages 45-54)											
PCR: Observed Readmission Rate - Total Stays (Ages 55-64)	12.61%	11.26%	8.54%	10.49%	10.31%	12.03%	11.16%	8.29%	10.59%		
PCR: Observed Readmission Rate - Total Stays (Ages Total)	11.01%	9.85%	6.69%	10.57%	8.31%	11.21%	10.24%	7.07%	9.37%		
PCR: Expected Readmission Rate - Total Stays (Ages 18-44)	8.68%	8.32%	8.36%	8.26%	7.92%	8.31%	8.53%	8.04%	8.30%		
PCR: Expected Readmission Rate - Total Stays (Ages 45-54)	10.32%	10.11%	10.11%	10.15%	9.46%	10.19%	10.22%	9.51%	10.01%		
PCR: Expected Readmission Rate - Total Stays (Ages 55-64)	11.93%	11.94%	11.87%	11.68%	11.27%	11.80%	11.82%	11.21%	11.69%		
PCR: Expected Readmission Rate - Total Stays (Ages Total)	9.94%	9.83%	9.83%	9.73%	9.21%	9.71%	9.83%	9.36%	9.68%		
PCR: Observed to Expected Readmission Ratio - Total Stays (Ages Total)	1.11	1.00	0.68	1.09	0.90	1.15	1.04	0.76	0.97		
Measures Reported Using Electronic Clinical Data Systems											
Prenatal Immunization Status (PRS-E)											
PRS-E: Influenza	28.38%	34.41%	32.09%	37.95%	30.27%	35.85%	35.36%	33.00%	33.41%	33.63%	▼
PRS-E: Tdap	66.66%	70.40%	67.91%	68.67%	66.57%	65.59%	65.16%	68.96%	67.49%	67.59%	▼
PRS-E: Combination	24.43%	29.98%	28.22%	33.23%	26.40%	30.59%	30.46%	29.22%	29.07%	29.26%	▼
Breast Cancer Screening (BCS-E)											
BCS-E: Rate	41.89%	55.49%	55.24%	51.57%	48.57%	49.47%	47.58%	51.79%	50.20%	50.77%	N/A

PH-MCO HEDIS Measure	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA DHS MEAN	Weighted Average	
Follow-up Care for Children Prescribed ADHD Medication (ADD-E)											
ADD-E: Initiation Phase	28.98%	43.17%	42.34%	44.62%	42.13%	35.36%	34.92%	48.19%	39.96%	41.10%	N/A
ADD-E: Continuation and Maintenance Phase	35.00%	51.15%	44.35%	47.96%	49.88%	44.30%	41.92%	57.54%	46.51%	48.54%	N/A
Prenatal Depression Screening and Follow-Up (PND-E)											
PND-E: Depression Screening	0.00%	21.28%	44.57%	36.46%	0.00%	40.02%	22.17%	33.39%	24.74%	26.41%	N/A
PND-E: Follow-Up on Positive Screen	N/A	52.27%	59.59%	37.95%	N/A	46.86%	59.62%	57.48%	52.30%	41.33%	N/A
Postpartum Depression Screening and Follow-Up (PDS-E)											
PDS-E: Depression Screening	0.00%	23.11%	32.91%	38.77%	0.00%	20.85%	2.01%	41.13%	19.85%	21.79%	N/A
PDS-E: Follow-Up on Positive Screen	N/A	75.68%	55.12%	39.16%	N/A	46.81%	100.00%	59.22%	62.67%	48.25%	N/A
Adult Immunization Status (AIS-E)											
AIS-E: Influenza	13.02%	21.23%	19.86%	13.17%	18.65%	20.96%	18.26%	19.83%	18.12%	18.46%	N/A
AIS-E: Tdap	37.52%	48.22%	49.92%	41.20%	47.66%	37.24%	34.02%	45.78%	42.70%	42.67%	N/A
AIS-E: Zoster	5.49%	11.35%	12.17%	3.49%	8.18%	8.38%	8.09%	9.15%	8.29%	8.37%	N/A
Depression Screening and Follow-up for Adolescents and Adults (DSF-E) – Adolescent age cohort only											
DSF-E: Depression Screening Ages 12 - 17 years	0.00%	0.35%	10.85%	4.65%	0.00%	0.24%	0.09%	2.78%	2.37%	2.11%	N/A
DSF-E: Follow-Up on Positive Screen Ages 12 - 17 years	N/A	100.00%	77.70%	32.22%	N/A	57.14%	100.00%	87.68%	75.79%	59.86%	N/A

[1] For the Non-Recommended Cervical Cancer Screening in Adolescent Females measure, lower rate indicates better performance.
[2] For HbA1c Poor Control, lower rates indicate better performance.
[3] For the Risk of Continued Opioid Use measure, lower rates indicate better performance.
[4] For the Use of Opioids at High Dosage measure, lower rates indicate better performance.
[5] For the Use of Opioids From Multiple Providers measure, lower rates indicate better performance.
Note: Gray shading indicates IPRO does not provide or calculate these rates.

In addition to HEDIS, PH-MCOs are required to calculate PAPMs, which are validated by IPRO on an annual basis. The individual PH-MCO reports include:

- A description of each PAPM,
- The MCO's review year measure rates with 95% upper and lower confidence intervals (95% CI),
- Two years of data (the MY and previous year) and the MMC rate, and
- Comparisons to the MCO's previous year rate and to the MMC rate.

Results for PAPMs are presented for each PH-MCO in **Table 6b**, along with the PH MMC average and PH MMC weighted average, which takes into account the proportional relevance of each MCO. Any Child Core Set Measure reported in **Table 6b** are Medicaid-only rates, including the weighted average rates. Child Core Set measures are indicated below with an *.

Table 6b: PH-MCO Results for 2022 (MY 2021) PAPMs

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Annual Dental Visits for Members with Developmental Disabilities (ADD – Age 2-20 years)										
Annual Dental Visits for Members with Developmental Disabilities: Rate	53.18%	65.59%	54.83%	55.75%	63.88%	68.51%	59.34%	59.96%	60.13%	61.52%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit (PSS)										
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking	76.98%	71.13%	92.45%	83.42%	40.47%	80.90%	85.93%	81.03%	76.54%	75.93%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA Indicator)	76.49%	70.42%	92.45%	83.17%	39.83%	79.72%	83.95%	80.77%	75.85%	75.24%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure	55.45%	46.24%	51.42%	56.44%	13.28%	54.25%	53.09%	53.59%	47.97%	47.34%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking	81.40%	65.14%	79.39%	71.25%	69.57%	53.95%	75.41%	72.00%	71.01%	71.80%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke	82.05%	58.00%	83.53%	73.91%	33.33%	57.14%	79.07%	91.43%	69.81%	73.11%

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation	20.83%	36.79%	19.85%	18.64%	25.40%	54.67%	28.57%	29.00%	29.22%	29.12%
Perinatal Depression Screening (PDS)										
Perinatal Depression Screening: Prenatal Screen for Depression	70.54%	69.25%	82.46%	84.65%	44.75%	78.77%	85.93%	70.28%	73.33%	72.80%
Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA Indicator)	68.07%	58.45%	82.46%	80.69%	35.33%	66.98%	81.48%	28.94%	62.80%	62.42%
Perinatal Depression Screening: Prenatal Screening Positive for Depression	13.68%	23.39%	24.32%	20.76%	31.10%	15.27%	25.29%	16.80%	21.33%	20.88%
Perinatal Depression Screening: Prenatal Counseling for Depression	82.05%	71.01%	80.00%	70.42%	87.69%	64.71%	81.82%	78.46%	77.02%	77.27%
Perinatal Depression Screening: Postpartum Screening for Depression	72.49%	77.78%	86.93%	80.47%	61.82%	76.23%	90.00%	71.87%	77.20%	77.21%
Perinatal Depression Screening: Postpartum Screening Positive for Depression	14.73%	14.29%	23.20%	8.82%	19.35%	14.83%	20.88%	20.85%	17.12%	17.19%
Perinatal Depression Screening: Postpartum Counseling for Depression	87.88%	80.00%	87.32%	91.67%	85.71%	79.49%	88.71%	93.88%	86.83%	86.94%
Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication* (include the BH data) (ADD-CH)										
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication: Initiation Phase	29.03%	43.19%	42.35%	44.68%	42.31%	35.68%	34.75%	48.51%	40.06%	41.23%
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication: Continuation Phase	34.98%	51.53%	44.26%	47.96%	50.22%	45.80%	42.14%	58.11%	46.88%	48.93%
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (BH Enhanced): Initiation Phase	28.70%	42.30%	41.49%	44.45%	40.91%	35.02%	33.22%	46.59%	39.09%	39.95%
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder	33.92%	50.91%	45.95%	46.04%	48.21%	43.98%	41.58%	56.20%	45.85%	48.10%

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
(ADHD) Medication (BH Enhanced): Continuation Phase										
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)										
SAA Rate: MCO Defined	50.98%	64.50%	64.21%	59.02%	64.05%	62.76%	53.71%	65.42%	60.58%	61.30%
SAA Rate: BH ED Enhanced	57.32%	66.96%	65.07%	62.55%	71.31%	66.04%	63.85%	71.68%	65.60%	66.33%
Asthma in Children and Younger Adults Admission Rate (AAR) (PQI 15)										
Asthma in Children and Younger Adults Admission Rate (Age 2-17 years) per 100,000 member months[1]	4.38	7.67	4.66	15.38	8.98	18.43	7.50	6.83	9.23	10.07
Asthma in Children and Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months[1]	3.08	4.13	5.00	6.75	5.14	9.19	6.61	3.11	5.38	5.47
Asthma in Children and Younger Adults Admission Rate (Age 2-39 years) per 100,000 member months[1]	3.67	6.04	4.82	10.96	7.23	14.30	7.05	5.00	7.38	7.85
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (COPD) (PQI 05)										
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 40-64 years) per 100,000 member months[1]	19.29	22.24	27.41	37.93	41.20	54.97	41.21	27.54	33.97	34.84
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 65+ years) per 100,000 member months[1]	0.00	5.82	65.88	111.17	25.25	40.86	18.15	61.09	41.03	44.37
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 40+ years) per 100,000 member months[1]	18.88	21.88	27.92	40.34	40.92	54.47	40.61	27.94	34.12	35.06
Diabetes Short-Term Complications Admission Rate (DAR) (PQI 01)										
Diabetes Short-Term Complications Admission Rate (18-64 Years) per 100,000 member months[1]	11.10	17.82	18.59	15.70	24.23	22.45	17.22	16.71	17.98	18.19
Diabetes Short-Term Complications Admission Rate (65+ Years) per 100,000 member months[1]	0.00	11.64	13.18	4.12	8.42	15.32	0.00	13.57	8.28	9.01

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Diabetes Short-Term Complications Admission Rate (Age 18+ Years) per 100,000 member months[1]	11.02	17.77	18.57	15.55	24.13	22.35	17.05	16.69	17.89	18.11
Heart Failure Admission Rate (HF) (PQI 08)										
Heart Failure Admission Rate (18-64 Years) per 100,000 member months[1]	13.70	16.76	18.26	24.56	24.40	29.02	23.25	15.94	20.74	20.96
Heart Failure Admission Rate (65+ Years) per 100,000 member months[1]	38.82	75.67	79.06	107.05	193.62	66.39	36.30	101.81	87.34	83.20
Heart Failure Admission Rate (Age 18+ Years) per 100,000 member months[1]	13.89	17.27	18.57	25.61	25.52	29.53	23.37	16.36	21.27	21.51
Developmental Screening in the First Three Years of Life* (CHIPRA Measure DEV-CH)										
Developmental Screening in the First Three Years of Life: Total	58.46%	58.14%	50.25%	51.49%	61.60%	61.04%	63.04%	71.51%	59.44%	60.77%
Developmental Screening in the First Three Years of Life: 1 year	54.99%	52.86%	39.61%	48.35%	57.34%	59.79%	62.00%	69.81%	55.59%	57.42%
Developmental Screening in the First Three Years of Life: 2 years	59.08%	59.13%	50.77%	52.19%	62.31%	62.42%	63.49%	71.65%	60.13%	61.46%
Developmental Screening in the First Three Years of Life: 3 years	60.93%	61.85%	59.07%	53.49%	64.75%	60.59%	63.46%	72.99%	62.14%	62.98%
Sealant Receipt on Permanent First Molars* (SFM-CH)										
Sealant Receipt on Permanent First Molars: ≥ 1 Molar	32.87%	19.09%	48.39%	51.82%	55.73%	18.29%	31.74%	30.74%	36.08%	34.00%
Sealant Receipt on Permanent First Molars: All 4 Molars	20.25%	10.95%	30.76%	34.36%	41.38%	9.89%	19.15%	16.85%	22.95%	21.37%
Contraceptive Care for all Women* (CCW)										
Contraceptive Care for all Women: Provision of most or moderately effective contraception (Ages 15-20)	28.93%	30.55%	33.54%	23.22%	31.12%	24.13%	28.28%	35.88%	29.46%	29.43%
Contraceptive Care for all Women: Provision of LARC contraception (Ages 15-20)	2.79%	4.09%	3.13%	2.62%	3.74%	2.60%	2.99%	4.09%	3.26%	3.29%
Contraceptive Care for all Women: Provision of most or moderately effective contraception (Ages 21-44)	24.93%	27.98%	26.65%	26.13%	26.25%	27.31%	25.91%	26.92%	26.51%	26.64%

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Contraceptive Care for all Women: Provision of LARC (Ages 21-44)	3.74%	5.06%	3.92%	3.84%	4.28%	3.91%	4.10%	4.54%	4.17%	4.20%
Contraceptive Care for all Women: Provision of most or moderately effective contraception (Ages 15-44)	25.78%	28.62%	28.35%	25.50%	27.52%	26.46%	26.51%	28.88%	27.20%	27.32%
Contraceptive Care for all Women: Provision of LARC (Ages 15-44)	3.54%	4.82%	3.72%	3.58%	4.13%	3.56%	3.81%	4.44%	3.95%	3.98%
Contraceptive Care for Postpartum Women* (CCP)										
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15-20)	10.66%	16.70%	8.60%	23.77%	8.48%	23.47%	12.35%	9.73%	14.22%	14.54%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15-20)	37.87%	53.55%	37.99%	46.96%	39.64%	47.11%	36.18%	45.66%	43.12%	44.13%
Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15-20)	4.41%	10.56%	4.66%	15.07%	5.52%	13.54%	7.06%	5.31%	8.27%	8.54%
Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15-20)	9.19%	22.46%	11.11%	21.16%	12.43%	17.69%	13.24%	15.75%	15.38%	15.99%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 21-44)	14.42%	18.80%	16.34%	22.92%	17.29%	20.55%	17.61%	15.09%	17.88%	18.01%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21-44)	39.45%	47.54%	39.13%	44.22%	41.31%	43.12%	40.83%	40.73%	42.04%	42.32%
Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21-44)	3.52%	6.00%	4.17%	9.53%	5.14%	7.09%	5.19%	3.58%	5.53%	5.60%
Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21-44)	9.88%	13.86%	9.50%	14.51%	11.74%	12.14%	11.27%	11.49%	11.80%	11.97%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15-44)	14.11%	18.58%	15.59%	22.99%	16.21%	20.80%	17.08%	14.62%	17.50%	17.68%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15-44)	39.32%	48.18%	39.02%	44.46%	41.11%	43.47%	40.37%	41.16%	42.14%	42.49%

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15-44)	3.60%	6.49%	4.22%	10.01%	5.19%	7.65%	5.38%	3.73%	5.78%	5.88%
Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15-44)	9.82%	14.78%	9.66%	15.09%	11.82%	12.63%	11.47%	11.87%	12.14%	12.36%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%) (HPCMI-AD)										
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%): Ages 18-64 years[2]	76.89%	81.33%	87.13%	90.54%	66.19%	92.96%	91.20%	73.67%	73.32%	81.12%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%): Ages 65-75 years[2]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	79.36%	84.44%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%): Ages: Total[2]	76.92%	81.36%	87.15%	90.54%	66.19%	92.95%	91.25%	73.64%	73.33%	81.14%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)										
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1-11 years	55.56%	60.82%	73.88%	57.14%	61.27%	60.00%	57.47%	60.16%	60.79%	61.43%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 12-17 years	58.48%	65.26%	67.46%	70.21%	65.04%	56.68%	62.13%	65.85%	63.89%	63.73%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages Total	57.64%	63.76%	69.69%	66.67%	64.07%	57.52%	60.87%	64.31%	63.07%	63.07%
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence (FUA)										
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 18-64 (7 days)	18.32%	17.48%	16.85%	23.88%	17.51%	20.95%	17.75%	18.27%	18.87%	19.09%
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 18-64 (30 days)	28.42%	26.01%	27.27%	31.89%	27.39%	31.96%	27.15%	29.24%	28.67%	29.03%
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 65+ (7 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	17.50%	25.00%

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 65+ (30 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	20.63%	29.17%
Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM)										
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 18-64 (7 days)	39.90%	41.47%	52.05%	40.55%	41.91%	36.89%	35.22%	37.08%	40.63%	40.36%
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 18-64 (30 days)	50.40%	54.53%	64.79%	50.44%	55.59%	48.23%	48.59%	53.03%	53.20%	53.31%
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 65+ (7 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41.67%	50.00%
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 65+ (30 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48.96%	64.29%
Concurrent Use of Opioids and Benzodiazepines (COB)										
Concurrent Use of Opioids and Benzodiazepines: Ages 18-64 years	11.66%	20.79%	19.35%	15.10%	17.89%	20.48%	12.16%	14.96%	16.55%	16.53%
Concurrent Use of Opioids and Benzodiazepines: Ages 65+	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	14.40%	13.25%
Concurrent Use of Opioids and Benzodiazepines: Ages: Total	11.70%	20.71%	19.42%	15.12%	17.84%	20.47%	12.14%	14.94%	16.54%	16.52%
Adult Annual Dental Visit ≥ 21 Years (AADV)										
Adult Annual Dental Visit ≥ 21 Years: (Ages 21-35 years)	22.49%	30.60%	27.40%	27.88%	28.99%	32.68%	25.85%	27.98%	24.56%	28.58%
Adult Annual Dental Visit ≥ 21 Years: (Ages 36-59 years)	21.38%	28.31%	25.76%	27.19%	26.96%	29.69%	24.22%	25.67%	22.93%	26.65%
Adult Annual Dental Visit ≥ 21 Years: (Ages 60-64 years)	19.85%	23.51%	22.56%	24.34%	22.75%	26.20%	21.82%	22.72%	20.15%	23.40%
Adult Annual Dental Visit ≥ 21 Years: (Ages 65+ years)	13.78%	17.40%	14.83%	18.55%	18.78%	19.49%	17.00%	15.49%	15.06%	17.81%
Adult Annual Dental Visit ≥ 21 Years: (Ages Total)	21.76%	28.89%	26.21%	27.20%	27.53%	30.63%	24.76%	26.37%	23.39%	27.21%

PH-MCO PAPMs	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Adult Annual Dental Visit: Women with a Live Birth (21-35 years)	27.91%	31.85%	30.81%	33.76%	31.83%	35.26%	29.59%	30.84%	27.63%	31.98%
Adult Annual Dental Visit: Women with a Live Birth (36-59 years)	20.30%	33.93%	29.61%	30.30%	30.53%	33.45%	26.11%	24.77%	24.92%	29.21%
Adult Annual Dental Visit: Women with a Live Birth (21-59 years)	27.05%	32.09%	30.67%	33.32%	31.70%	35.01%	29.17%	30.14%	27.31%	31.64%
Use of Pharmacotherapy for Opioid Use Disorder (OUD)										
Use of Pharmacotherapy for Opioid Use Disorder: Total	71.83%	72.92%	76.83%	66.07%	80.82%	62.88%	76.67%	80.47%	65.39%	76.20%
Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine	67.00%	69.44%	73.65%	65.00%	77.64%	60.54%	72.94%	73.72%	62.21%	71.87%
Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone	3.62%	3.18%	2.40%	1.43%	2.15%	1.67%	3.89%	3.10%	2.38%	2.78%
Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone	6.24%	4.39%	3.94%	2.86%	4.30%	2.68%	5.29%	5.97%	3.96%	4.81%
Use of Pharmacotherapy for Opioid Use Disorder: Methadone	0.20%	0.15%	0.10%	0.71%	0.56%	0.84%	0.31%	5.04%	0.88%	1.83%
Oral Evaluation, Dental Services* (OEV-CH)										
Oral Evaluation, Dental Services (Age <1-20 years)	33.98%	45.62%	37.04%	47.36%	40.61%	55.92%	4.22%	0.39%	33.14%	33.58%
Topical Fluoride for Children* (TFL-CH)										
Topical Fluoride for Children (Dental or Oral Health Services)	16.63%	16.97%	17.46%	18.26%	13.85%	23.51%	17.06%	13.27%	17.13%	17.39%
Topical Fluoride for Children (Total Dental Services)	12.35%	15.47%	12.98%	14.74%	11.97%	21.57%	0.54%	0.00%	11.20%	11.51%
Topical Fluoride for Children (Total Oral Health Services)	0.90%	0.91%	0.00%	0.00%	1.06%	0.99%	1.03%	0.00%	0.98%	0.61%

[1] For the Adult Admission Rate measures, lower rates indicate better performance.

[2] For the Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0% ; HPCMI-AD), lower rates indicate better performance.

CHIP-MCO Performance Measures

Each CHIP-MCO underwent a full HEDIS Compliance Audit in 2022. Each year, DHS updates its requirements for the CHIP-MCOs to be consistent with NCQA's requirement for the reporting year. CHIP-MCOs are required to report the complete set of CHIP measures mandated by DHS, as specified in the *HEDIS MY 2021: Volume 2: Technical Specifications*. All CHIP-MCO HEDIS rates are compiled and provided to DHS CHIP on an annual basis. The individual MCO 2022 (MY 2021) EQR reports include these measures. **Table 7a** represents the HEDIS performance for all 10 CHIP-MCOs in 2022, as well as the CHIP mean and the CHIP weighted average; this table includes the full set of HEDIS MY 2021 measures reported to DHS CHIP. If the denominator was less than 30 for a particular rate, "N/A" (Not Applicable) appears in the corresponding cells. For HEDIS measures that report age cohorts beyond 19 years old, rates reported below only extend to 19 years old to align with CHIP enrollment and are noted as such. In these cases, age stratifications will differ from HEDIS MY 2021 technical specifications.

Table 7a: CHIP-MCO Results for 2022 (MY 2021) HEDIS Measures

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
Effectiveness of Care													
Prevention and Screening													
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) - Hybrid													
WCC: BMI Ages 3 - 11 years	86.02%	83.00%	88.24%	86.43%	81.58%	80.50%	90.06%	81.88%	88.24%	78.86%	84.48%	84.45%	▲
WCC: BMI Ages 12 - 17 years	87.43%	78.89%	81.75%	80.12%	81.70%	87.01%	83.04%	83.43%	81.58%	75.38%	82.03%	81.15%	▲
WCC: BMI Ages 3 - 17 years Total Rate	86.62%	81.05%	85.47%	83.61%	81.64%	83.71%	86.55%	82.69%	85.16%	77.38%	83.39%	82.95%	▲
WCC: Nutrition Ages 3 - 11 years	77.12%	72.00%	83.53%	83.92%	80.92%	76.10%	90.06%	81.88%	82.81%	70.86%	79.92%	78.75%	▼
WCC: Nutrition Ages 12 - 17 years	82.86%	72.78%	69.05%	72.67%	79.74%	70.78%	83.04%	81.14%	78.42%	63.85%	75.43%	74.33%	▼
WCC: Nutrition Ages 3 - 17 years Total Rate	79.56%	72.37%	77.36%	78.89%	80.33%	73.48%	86.55%	81.49%	80.78%	67.87%	77.87%	76.74%	▼
WCC: Physical Activity Ages 3 - 11 years	75.85%	65.00%	74.71%	75.38%	77.63%	72.33%	81.29%	80.63%	79.64%	70.86%	75.33%	74.86%	▼
WCC: Physical Activity Ages 12 - 17 years	81.71%	71.67%	68.25%	68.94%	81.05%	71.43%	83.63%	80.00%	81.58%	63.08%	75.13%	74.33%	▼
WCC: Physical Activity Ages 3 - 17 Total Rate	78.35%	68.16%	71.96%	72.50%	79.34%	71.88%	82.46%	80.30%	80.54%	67.54%	75.30%	74.65%	▼
Childhood Immunization Status (CIS) - Hybrid													
CIS: DTaP	80.59%	79.17%	78.90%	73.44%	89.13%	79.76%	82.95%	N/A	86.99%	87.56%	82.05%	83.74%	▼
CIS: IPV	86.92%	86.67%	84.40%	87.50%	97.83%	85.71%	91.47%	N/A	93.84%	92.93%	89.70%	90.48%	▼
CIS: MMR	85.23%	89.17%	86.24%	89.06%	95.65%	83.33%	91.47%	N/A	91.44%	90.73%	89.15%	89.31%	▼
CIS: HiB	87.34%	87.50%	85.32%	87.50%	97.83%	84.52%	90.70%	N/A	93.49%	92.93%	89.68%	90.48%	▼
CIS: Hepatitis B	85.65%	85.83%	83.49%	89.06%	95.65%	84.52%	89.15%	N/A	91.78%	91.71%	88.54%	89.14%	▼
CIS: VZV	86.08%	86.67%	82.57%	87.50%	97.83%	82.14%	91.47%	N/A	92.12%	92.20%	88.73%	89.48%	▼
CIS: Pneumococcal Conjugate	81.86%	80.83%	81.65%	75.00%	89.13%	79.76%	87.60%	N/A	88.70%	87.80%	83.59%	85.12%	▼

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
CIS: Hepatitis A	82.70%	84.17%	79.82%	84.38%	95.65%	79.76%	86.05%	N/A	89.73%	88.29%	85.62%	86.18%	▼
CIS: Rotavirus	75.95%	75.83%	74.31%	70.31%	86.96%	79.76%	82.17%	N/A	84.59%	84.39%	79.36%	80.78%	▼
CIS: Influenza	63.71%	63.33%	58.72%	62.50%	67.39%	60.71%	72.87%	N/A	69.86%	65.37%	64.94%	65.66%	▲
CIS: Combination 3	77.22%	78.33%	74.31%	67.19%	84.78%	75.00%	79.07%	N/A	83.90%	81.71%	77.95%	79.54%	▼
CIS: Combination 7	67.51%	70.00%	67.89%	59.38%	80.43%	72.62%	72.09%	N/A	78.08%	77.07%	71.67%	73.28%	▲
CIS: Combination 10	53.59%	57.50%	52.29%	46.88%	60.87%	54.76%	62.02%	N/A	60.96%	57.32%	56.24%	57.02%	▲
Immunizations for Adolescents (IMA) - Hybrid													
IMA: Meningococcal	88.08%	91.24%	89.29%	89.78%	91.07%	89.05%	90.51%	88.93%	89.29%	87.10%	89.43%	89.10%	▼
IMA: Tdap/Td	88.08%	91.97%	90.51%	91.00%	92.56%	89.78%	91.00%	89.93%	90.02%	87.83%	90.27%	89.83%	▼
IMA: HPV	37.96%	32.60%	36.74%	44.53%	37.47%	35.28%	42.34%	38.93%	39.66%	39.90%	38.54%	38.90%	▲
IMA: Combination 1	87.10%	90.02%	89.05%	89.54%	90.82%	88.56%	89.54%	88.59%	88.81%	86.62%	88.87%	88.49%	▼
IMA: Combination 2	37.71%	31.87%	36.25%	44.04%	36.97%	35.04%	41.36%	38.93%	39.66%	39.90%	38.17%	38.58%	▲
Lead Screening in Children (LSC) - Hybrid													
LSC: Rate	66.24%	55.00%	55.96%	65.63%	82.61%	55.95%	57.36%	N/A	72.35%	75.37%	65.16%	67.63%	▼
Chlamydia Screening in Women (CHL)													
CHL: Ages 16 - 19 years	39.33%	29.01%	35.71%	46.64%	32.03%	28.09%	44.79%	32.37%	40.02%	34.05%	36.20%	36.49%	▼
Respiratory Conditions													
Asthma Medication Ratio (AMR)													
AMR: 5 - 11 years	80.00%	80.30%	92.45%	74.14%	N/A	84.85%	63.92%	N/A	76.26%	88.37%	80.04%	79.26%	▼
AMR: 12 - 18 years	60.00%	83.15%	87.50%	77.61%	75.00%	92.73%	73.85%	N/A	63.27%	72.78%	76.21%	73.79%	▲
AMR: 19 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
AMR: Total	70.53%	82.05%	90.00%	76.19%	80.33%	89.89%	69.74%	72.97%	69.44%	79.93%	78.11%	76.43%	▲
Appropriate Testing for Pharyngitis (CWP)													
CWP: 3 - 17 years	80.43%	78.47%	73.72%	66.29%	78.98%	77.01%	75.31%	73.64%	82.11%	82.45%	76.84%	79.07%	▼
CWP: 18 years	N/A	N/A	83.33%	N/A	N/A	N/A	N/A	N/A	84.31%	78.46%	82.03%	81.50%	▲
CWP: Total Rate	79.40%	77.93%	74.61%	67.37%	79.33%	77.07%	75.27%	75.59%	82.32%	82.15%	77.10%	79.13%	▼
Appropriate Treatment for Upper Respiratory Infection (URI)													
URI: 3 - 17 years	95.93%	96.10%	93.53%	96.54%	95.57%	94.87%	95.43%	94.63%	95.52%	96.14%	95.43%	95.57%	▲
URI: 18 years	N/A	90.00%	N/A	N/A	95.00%	N/A	N/A	N/A	100.00%	96.30%	95.33%	96.02%	▲
URI: Total Rate	95.89%	95.84%	93.05%	96.35%	95.52%	94.62%	95.20%	94.51%	95.67%	96.15%	95.28%	95.48%	▲
Behavioral Health													
Follow-up Care for Children Prescribed ADHD Medication (ADD)													
ADD: Initiation Phase	37.27%	36.75%	47.47%	31.71%	42.86%	42.27%	21.57%	N/A	42.72%	50.00%	39.18%	41.70%	▼

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
ADD: Continuation and Maintenance Phase	N/A	41.94%	N/A	N/A	N/A	N/A	N/A	N/A	66.67%	60.49%	56.37%	58.28%	▲
Follow up After Hospitalization for Mental Illness (FUH)													
FUH: 7 Days	41.30%	50.00%	51.67%	N/A	50.00%	55.00%	54.55%	N/A	49.40%	48.70%	50.08%	49.83%	▼
FUH: 30 Days	58.70%	79.63%	76.67%	N/A	90.63%	82.50%	62.12%	N/A	65.06%	80.83%	74.52%	74.74%	▲
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)													
APM: Blood Glucose Testing Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
APM: Blood Glucose Testing Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	70.31%	70.31%	70.31%	▲
APM: Blood Glucose Testing Total Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	68.92%	68.92%	68.92%	▲
APM: Cholesterol Testing Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
APM: Cholesterol Testing Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	46.88%	46.88%	46.88%	▼
APM: Cholesterol Testing Total Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.00%	50.00%	50.00%	▼
APM: Blood Glucose & Cholesterol Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
APM: Blood Glucose & Cholesterol Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	46.88%	46.88%	46.88%	▲
APM: Blood Glucose & Cholesterol Total Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48.65%	48.65%	48.65%	▼
Access/Availability of Care													
Annual Dental Visits (ADV)													
ADV: Ages 2 - 3 years	44.46%	27.34%	37.39%	48.35%	30.29%	37.54%	54.62%	35.71%	42.02%	34.11%	39.18%	39.48%	▼
ADV: Ages 4 - 6 years	65.57%	61.28%	59.98%	68.84%	60.67%	65.05%	74.28%	63.80%	64.76%	62.99%	64.72%	64.79%	▲
ADV: Ages 7 - 10 years	67.65%	69.99%	69.85%	69.02%	64.73%	69.38%	75.45%	69.21%	67.63%	66.02%	68.89%	68.69%	▼
ADV: Ages 11 - 14 years	63.00%	65.30%	61.60%	66.69%	62.56%	65.49%	71.67%	68.19%	64.00%	60.37%	64.89%	64.32%	▼
ADV: Ages 15 - 18 years	52.03%	55.51%	52.53%	52.91%	58.33%	57.27%	60.94%	60.81%	53.48%	50.44%	55.43%	54.43%	▼
ADV: Ages 19 years	34.78%	41.67%	36.51%	34.69%	30.77%	53.85%	45.35%	N/A	33.04%	39.37%	38.89%	38.42%	▼
ADV: Ages 2-19 years Total Rate	60.54%	61.61%	59.86%	62.93%	59.95%	62.90%	68.91%	64.35%	61.00%	58.08%	62.01%	61.49%	▼
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)													
APP: Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
APP: Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	68.75%	68.75%	68.75%	▼
APP: Ages 1 - 17 years Total Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	66.04%	66.04%	66.04%	▲
Use of Services													
Well-Child Visits in the First 30 Months of Life (W30)													
W30: ≥ 6 visits 15 months	52.38%	69.49%	50.00%	38.71%	51.43%	40.74%	50.48%	N/A	58.18%	71.51%	53.66%	59.32%	▲
W30: ≥ 2 visits 30 months	85.67%	85.21%	80.61%	72.83%	82.95%	89.58%	85.94%	82.26%	85.84%	89.37%	84.03%	85.76%	▼
Child and Adolescent Well-Care Visits (WCV)													
WCV: 3 - 11 years	64.21%	64.28%	65.50%	63.41%	67.38%	67.15%	71.71%	66.21%	67.59%	68.69%	66.61%	67.08%	▲
WCV: 12 - 17 years	59.69%	62.22%	59.28%	60.45%	65.76%	63.54%	68.53%	64.76%	63.59%	64.17%	63.20%	63.36%	▼
WCV: 18 - 19 years	44.95%	46.81%	47.39%	45.06%	53.31%	51.30%	56.91%	47.10%	48.75%	52.85%	49.44%	50.08%	▼
WCV: 3 - 19 years	61.02%	62.13%	61.67%	60.75%	65.32%	64.46%	69.08%	64.03%	64.57%	65.68%	63.87%	64.25%	▼
Ambulatory Care: Total (AMBA)													
AMBA: Outpatient Visits/1000 MM Ages <1 year	616.37	596.14	611.97	435.98	574.00	727.43	575.86	695.54	599.04	790.37	622.27	652.55	▼
AMBA: Outpatient Visits/1000 MM Ages 1 - 9 years	191.81	193.54	226.25	153.60	217.68	230.32	167.95	215.04	216.76	278.86	209.18	218.78	▼
AMBA: Outpatient Visits/1000 MM Ages 10 - 19 years	176.87	211.73	229.08	149.02	236.41	243.68	168.93	215.85	212.73	269.42	211.37	215.21	▼
AMBA: Outpatient Visits/1000 MM Ages <1 - 19 years Total Rate	188.83	207.43	232.16	153.04	233.23	243.19	171.92	219.28	218.25	279.96	214.73	221.18	▼
AMBA: Emergency Department Visits/1000 MM Ages <1 year	36.04	17.48	40.10	24.28	28.31	34.51	32.22	34.65	29.24	32.77	30.96	31.92	▼
AMBA: Emergency Department Visits/1000 MM Ages 1 - 9 years	16.87	13.61	16.49	15.70	19.09	14.06	14.65	16.42	17.33	18.29	16.25	16.58	▼
AMBA: Emergency Department Visits/1000 MM Ages 10 - 19 years	15.11	14.07	18.23	13.31	20.12	14.68	14.50	18.11	16.41	20.26	16.48	16.69	▼
AMBA: Emergency Department Visits/1000 MM Ages <1 - 19 years Total Rate	16.11	13.91	17.75	14.29	19.84	14.63	14.70	17.64	16.91	19.60	16.54	16.80	▼
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)													
IPUA: Total Discharges/1000 MM Ages <1 year	1.68	0.92	3.70	0.00	1.29	2.65	4.69	4.95	1.21	1.38	2.25		
IPUA: Total Discharges/1000 MM Ages 1 - 9 years	0.24	0.40	0.64	0.28	0.36	0.29	0.72	0.60	0.33	0.45	0.43		

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
IPUA: Total Discharges/1000 MM Ages 10 - 19 years	0.55	0.56	0.74	0.71	0.39	0.73	0.74	0.42	0.65	0.77	0.63		
IPUA: Total Discharges/1000 MM Ages <1 - 19 years Total Rate	0.43	0.50	0.73	0.54	0.39	0.57	0.76	0.52	0.53	0.65	0.56		
IPUA: Total Inpatient ALOS Ages <1 year	2.40	5.00	3.83	N/A	3.00	1.33	1.38	2.00	4.75	2.00	2.85		
IPUA: Total Inpatient ALOS Ages 1 - 9 years	2.73	2.38	2.21	2.17	2.90	2.00	2.66	2.09	4.30	1.97	2.54		
IPUA: Total Inpatient ALOS Ages 10 - 19 years	5.48	3.51	3.31	3.73	3.70	3.90	3.08	4.43	4.21	3.41	3.88		
IPUA: Total Inpatient ALOS Ages <1 - 19 years Total Rate	4.70	3.18	2.93	3.43	3.42	3.40	2.86	3.30	4.24	2.96	3.44		
IPUA: Surgery Discharges/1000 MM Ages <1 year	0.00	0.00	0.62	0.00	0.00	0.00	0.59	2.48	0.30	0.00	0.40		
IPUA: Surgery Discharges/1000 MM Ages 1 - 9 years	0.05	0.12	0.13	0.07	0.11	0.13	0.26	0.33	0.08	0.10	0.14		
IPUA: Surgery Discharges/1000 MM Ages 10 - 19 years	0.19	0.22	0.26	0.30	0.12	0.22	0.19	0.24	0.19	0.29	0.22		
IPUA: Surgery Discharges/1000 MM Ages <1 - 19 years Total Rate	0.13	0.18	0.21	0.21	0.11	0.19	0.22	0.29	0.15	0.21	0.19		
IPUA: Surgery ALOS Ages <1 year	N/A	N/A	14.00	N/A	N/A	N/A	1.00	3.00	5.00	N/A	5.75		
IPUA: Surgery ALOS Ages 1 - 9 years	5.40	3.86	1.63	3.67	4.00	2.17	3.53	2.33	3.91	2.06	3.26		
IPUA: Surgery ALOS Ages 10 - 19 years	6.28	3.10	4.95	5.48	3.00	6.73	5.44	6.13	6.51	4.31	5.19		
IPUA: Surgery ALOS Ages <1 - 19 years Total Rate	6.13	3.29	4.39	5.25	3.33	5.43	4.53	4.40	5.90	3.86	4.65		
IPUA: Medicine Discharges/1000 MM Ages <1 year	1.68	0.92	3.08	0.00	1.29	2.65	4.10	2.48	0.90	1.38	1.85		
IPUA: Medicine Discharges/1000 MM Ages 1 - 9 years	0.18	0.29	0.51	0.21	0.26	0.16	0.46	0.27	0.25	0.35	0.29		
IPUA: Medicine Discharges/1000 MM Ages 10 - 19 years	0.28	0.27	0.39	0.32	0.26	0.45	0.47	0.12	0.33	0.41	0.33		
IPUA: Medicine Discharges/1000 MM Ages <1 - 19 years Total Rate	0.26	0.28	0.47	0.28	0.27	0.35	0.50	0.19	0.30	0.40	0.33		
IPUA: Medicine ALOS Ages <1 year	2.40	5.00	1.80	N/A	3.00	1.33	1.43	1.00	4.67	2.00	2.51		

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
IPUA: Medicine ALOS Ages 1 - 9 years	1.94	1.76	2.35	1.67	2.43	1.86	2.18	1.80	4.42	1.95	2.24		
IPUA: Medicine ALOS Ages 10 - 19 years	5.22	4.16	2.24	2.59	4.15	2.57	2.17	2.25	3.33	2.74	3.14		
IPUA: Medicine ALOS Ages <1 - 19 years Total Rate	4.02	3.23	2.26	2.32	3.52	2.35	2.13	1.90	3.73	2.42	2.79		
IPUA: Maternity Discharges/1000 MM Ages 10 - 19 years	0.08	0.07	0.08	0.09	0.02	0.06	0.08	0.06	0.12	0.07	0.07		
IPUA: Maternity ALOS Ages 10 - 19 years Total Rate	4.40	2.43	3.14	1.83	2.00	3.25	2.90	2.00	3.00	3.56	2.85		
Mental Health Utilization (MPT)													
MPT: Any Services Ages 0 - 12 years - Male	2.69%	5.53%	6.22%	1.79%	9.42%	7.57%	3.59%	6.29%	4.11%	8.40%	5.56%		
MPT: Any Services Ages 0 - 12 years - Female	2.11%	4.98%	6.07%	1.75%	8.79%	7.60%	3.56%	6.04%	3.85%	8.00%	5.28%		
MPT: Any Services Ages 0 - 12 years - Total Rate	2.41%	5.26%	6.15%	1.77%	9.11%	7.58%	3.57%	6.17%	3.98%	8.20%	5.42%		
MPT: Any Services Ages 13 - 17 years - Male	4.05%	7.85%	8.00%	2.14%	10.46%	11.26%	4.99%	10.36%	5.98%	11.63%	7.67%		
MPT: Any Services Ages 13 - 17 years - Female	7.86%	17.10%	18.36%	5.95%	25.23%	19.83%	11.16%	19.01%	12.65%	24.97%	16.21%		
MPT: Any Services Ages 13 - 17 years - Total Rate	5.94%	12.55%	13.11%	4.05%	17.99%	15.60%	8.12%	14.66%	9.29%	18.33%	11.96%		
MPT: Inpatient Ages 0 - 12 years - Male	0.05%	0.05%	0.08%	0.00%	0.05%	0.04%	0.08%	0.00%	0.04%	0.11%	0.05%		
MPT: Inpatient Ages 0 - 12 years - Female	0.09%	0.11%	0.19%	0.18%	0.22%	0.14%	0.16%	0.17%	0.12%	0.18%	0.16%		
MPT: Inpatient Ages 0 - 12 years - Total Rate	0.07%	0.08%	0.13%	0.09%	0.14%	0.09%	0.12%	0.08%	0.08%	0.14%	0.10%		
MPT: Inpatient Ages 13 - 17 years – Male	0.50%	0.41%	0.60%	0.25%	0.51%	0.57%	0.45%	0.74%	0.24%	0.62%	0.49%		
MPT: Inpatient Ages 13 - 17 years - Female	1.08%	1.80%	1.50%	0.81%	1.14%	1.68%	1.21%	0.88%	1.12%	2.35%	1.36%		
MPT: Inpatient Ages 13 - 17 years - Total Rate	0.78%	1.11%	1.04%	0.53%	0.83%	1.13%	0.84%	0.81%	0.68%	1.49%	0.92%		

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average
MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Male	0.12%	0.10%	0.03%	0.15%	0.11%	0.18%	0.14%	0.00%	0.05%	0.08%	0.10%	
MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Female	0.15%	0.16%	0.03%	0.32%	0.06%	0.14%	0.35%	0.00%	0.07%	0.15%	0.14%	
MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Total Rate	0.14%	0.13%	0.03%	0.23%	0.08%	0.16%	0.24%	0.00%	0.06%	0.11%	0.12%	
MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Male	0.40%	0.32%	0.20%	0.06%	0.25%	0.70%	0.61%	0.00%	0.40%	0.17%	0.31%	
MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Female	0.64%	1.14%	0.36%	0.94%	0.97%	1.37%	1.21%	0.13%	0.76%	1.23%	0.88%	
MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Total Rate	0.52%	0.74%	0.28%	0.50%	0.62%	1.04%	0.91%	0.06%	0.58%	0.70%	0.60%	
MPT: Outpatient Ages 0 - 12 years - Male	2.03%	4.20%	4.23%	1.17%	7.01%	5.81%	2.25%	4.84%	3.15%	6.77%	4.15%	
MPT: Outpatient Ages 0 - 12 years - Female	1.50%	4.08%	4.32%	0.88%	6.45%	5.57%	2.16%	4.28%	2.76%	6.14%	3.81%	
MPT: Outpatient Ages 0 - 12 years - Total Rate	1.77%	4.14%	4.27%	1.02%	6.74%	5.69%	2.21%	4.56%	2.96%	6.46%	3.98%	
MPT: Outpatient Ages 13 - 17 years - Male	2.39%	6.08%	5.68%	1.39%	7.76%	8.34%	2.62%	7.03%	4.47%	8.59%	5.44%	
MPT: Outpatient Ages 13 - 17 years - Female	5.11%	13.11%	12.28%	3.32%	18.50%	14.61%	5.35%	12.38%	8.68%	18.33%	11.17%	
MPT: Outpatient Ages 13 - 17 years - Total Rate	3.74%	9.65%	8.94%	2.36%	13.23%	11.51%	4.00%	9.69%	6.57%	13.48%	8.32%	
MPT: ED Ages 0 - 12 years - Male	0.00%	0.00%	0.08%	0.00%	0.00%	0.04%	0.02%	0.00%	0.00%	0.00%	0.01%	
MPT: ED Ages 0 - 12 years - Female	0.00%	0.00%	0.05%	0.00%	0.00%	0.11%	0.02%	0.00%	0.01%	0.00%	0.02%	
MPT: ED Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.07%	0.00%	0.00%	0.07%	0.02%	0.00%	0.01%	0.00%	0.02%	
MPT: ED Ages 13 - 17 years - Male	0.00%	0.00%	0.15%	0.00%	0.17%	0.19%	0.03%	0.12%	0.02%	0.04%	0.07%	

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
MPT: ED Ages 13 - 17 years - Female	0.00%	0.04%	0.00%	0.00%	0.24%	0.25%	0.03%	0.13%	0.07%	0.09%	0.09%		
MPT: ED Ages 13 - 17 years - Total Rate	0.00%	0.02%	0.08%	0.00%	0.21%	0.22%	0.03%	0.12%	0.04%	0.07%	0.08%		
MPT: Telehealth Ages 0 - 12 years - Male	1.09%	2.90%	3.53%	0.84%	4.71%	3.85%	1.95%	3.15%	1.97%	4.41%	2.84%		
MPT: Telehealth Ages 0 - 12 years - Female	1.13%	2.25%	3.37%	0.91%	4.51%	4.87%	2.08%	3.86%	2.08%	4.66%	2.97%		
MPT: Telehealth Ages 0 - 12 years - Total Rate	1.11%	2.58%	3.45%	0.88%	4.61%	4.36%	2.01%	3.50%	2.03%	4.54%	2.91%		
MPT: Telehealth Ages 13 - 17 years - Male	2.06%	3.54%	4.53%	0.95%	5.82%	5.98%	3.00%	4.94%	3.23%	6.16%	4.02%		
MPT: Telehealth Ages 13 - 17 years - Female	4.07%	9.34%	12.17%	3.19%	15.01%	12.55%	7.49%	12.50%	7.25%	15.74%	9.93%		
MPT: Telehealth Ages 13 - 17 years - Total Rate	3.06%	6.49%	8.30%	2.07%	10.50%	9.31%	5.28%	8.69%	5.23%	10.97%	6.99%		
Identification of Alcohol and Other Drug Services (IAD)													
IAD: Any Services Ages 0 - 12 years - Male	0.00%	0.00%	0.05%	0.00%	0.00%	0.00%	0.02%	0.08%	0.02%	0.03%	0.02%		
IAD: Any Services Ages 0 - 12 years - Female	0.02%	0.03%	0.08%	0.00%	0.00%	0.04%	0.00%	0.00%	0.00%	0.02%	0.02%		
IAD: Any Services Ages 0 - 12 years - Total Rate	0.01%	0.01%	0.07%	0.00%	0.00%	0.02%	0.01%	0.04%	0.01%	0.02%	0.02%		
IAD: Any Services Ages 13 - 17 years - Male	0.76%	0.77%	1.06%	0.44%	1.01%	1.08%	0.83%	1.23%	0.64%	1.15%	0.90%		
IAD: Any Services Ages 13 - 17 years - Female	0.84%	0.75%	0.57%	0.50%	0.65%	0.93%	0.90%	1.25%	0.76%	1.18%	0.83%		
IAD: Any Services Ages 13 - 17 years - Total Rate	0.80%	0.76%	0.81%	0.47%	0.83%	1.01%	0.87%	1.24%	0.70%	1.16%	0.87%		
IAD: Inpatient Ages 0 - 12 years - Male	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%		
IAD: Inpatient Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Inpatient Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
IAD: Inpatient Ages 13 - 17 years - Male	0.13%	0.14%	0.25%	0.00%	0.17%	0.19%	0.16%	0.37%	0.09%	0.23%	0.17%		
IAD: Inpatient Ages 13 - 17 years – Female	0.13%	0.31%	0.26%	0.13%	0.32%	0.25%	0.19%	0.38%	0.22%	0.37%	0.26%		
IAD: Inpatient Ages 13 - 17 years - Total Rate	0.13%	0.22%	0.25%	0.06%	0.25%	0.22%	0.17%	0.37%	0.16%	0.30%	0.21%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.25%	0.19%	0.00%	0.00%	0.06%	0.05%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Female	0.03%	0.04%	0.00%	0.00%	0.00%	0.06%	0.09%	0.00%	0.07%	0.04%	0.03%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Total Rate	0.02%	0.02%	0.00%	0.00%	0.00%	0.16%	0.14%	0.00%	0.03%	0.05%	0.04%		
IAD: Outpatient Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.08%	0.01%	0.02%	0.01%		
IAD: Outpatient Ages 0 - 12 years - Female	0.02%	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%		
IAD: Outpatient Ages 0 - 12 years - Total Rate	0.01%	0.01%	0.01%	0.00%	0.00%	0.00%	0.01%	0.04%	0.01%	0.02%	0.01%		
IAD: Outpatient Ages 13 - 17 years - Male	0.27%	0.32%	0.55%	0.25%	0.42%	0.64%	0.45%	0.86%	0.24%	0.55%	0.45%		
IAD: Outpatient Ages 13 - 17 years - Female	0.44%	0.35%	0.31%	0.25%	0.24%	0.37%	0.25%	0.63%	0.29%	0.62%	0.38%		

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
IAD: Outpatient Ages 13 - 17 years - Total Rate	0.35%	0.33%	0.43%	0.25%	0.33%	0.50%	0.35%	0.75%	0.27%	0.58%	0.41%		
IAD: ED Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%		
IAD: ED Ages 0 - 12 years - Female	0.00%	0.03%	0.05%	0.00%	0.00%	0.04%	0.00%	0.00%	0.00%	0.00%	0.01%		
IAD: ED Ages 0 - 12 years - Total Rate	0.00%	0.01%	0.03%	0.00%	0.00%	0.02%	0.00%	0.00%	0.01%	0.00%	0.01%		
IAD: ED Ages 13 - 17 years - Male	0.40%	0.32%	0.20%	0.19%	0.42%	0.19%	0.29%	0.12%	0.27%	0.32%	0.27%		
IAD: ED Ages 13 - 17 years - Female	0.30%	0.22%	0.05%	0.13%	0.08%	0.19%	0.37%	0.50%	0.27%	0.22%	0.23%		
IAD: ED Ages 13 - 17 years - Total Rate	0.35%	0.27%	0.13%	0.16%	0.25%	0.19%	0.33%	0.31%	0.27%	0.27%	0.25%		
IAD: Telehealth Ages 0 - 12 years - Male	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%		
IAD: Telehealth Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Telehealth Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%		
IAD: Telehealth Ages 13 - 17 years - Male	0.07%	0.23%	0.20%	0.06%	0.25%	0.38%	0.06%	0.25%	0.18%	0.21%	0.19%		
IAD: Telehealth Ages 13 - 17 years - Female	0.03%	0.09%	0.21%	0.00%	0.24%	0.19%	0.16%	0.00%	0.00%	0.22%	0.11%		
IAD: Telehealth Ages 13 - 17 years - Total Rate	0.05%	0.16%	0.20%	0.03%	0.25%	0.28%	0.11%	0.12%	0.09%	0.22%	0.15%		

Gray shading indicates IPRO does not provide or calculate these rates.

In addition to HEDIS, CHIP-MCOs are required to calculate PAPMs, which are validated by IPRO on an annual basis. The individual CHIP-MCO reports include:

- A description of each PAPM,
- The MCO's review year rates with 95% upper and lower confidence intervals (95% CI),
- Two years of data (the MY and previous year) and the MMC rate, and
- Comparisons to the MCO's previous year rate and to the MMC rate.

Results for PAPMs are presented for each CHIP-MCO in **Table 7b**, along with the CHIP average and CHIP weighted average, which takes into account the proportional relevance of each MCO.

Table 7b: CHIP-MCO Results for 2022 (MY 2021) PAPMs

CHIP-MCO PAPMs	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	CHIP Average	CHIP Weighted Average
Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Rooms Visits												
Rate[1]	11.44%	6.34%	6.80%	10.82%	6.81%	6.29%	11.64%	6.16%	10.24%	8.11%	8.47%	9.14%
Contraceptive Care for Postpartum Women Ages 15-20 Years												
Most or moderately effective contraception-3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Most or moderately effective contraception-60 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LARC - 3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LARC - 60 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contraceptive Care for Women Ages 15-20 Years												
Provision of most or moderately effective contraception	17.71%	27.32%	29.66%	15.31%	33.53%	25.27%	18.38%	31.11%	21.27%	28.73%	24.83%	24.07%
Provision of LARC	1.66%	2.32%	1.96%	0.93%	4.18%	2.46%	1.33%	1.58%	1.43%	2.59%	2.05%	1.98%
Dental Sealants on Permanent First Molars (SFM-CH)												
≥ 1 Molar	32.86%	48.24%	45.87%	47.76%	37.90%	43.09%	50.56%	33.64%	34.28%	28.33%	40.25%	38.62%
All 4 Molars	21.61%	35.12%	30.93%	33.45%	30.61%	31.49%	36.80%	25.45%	23.51%	17.50%	28.65%	26.77%
Developmental Screening in the First Three Years of Life												
1 Year	72.73%	43.14%	43.55%	52.94%	76.00%	47.22%	65.22%	58.33%	74.56%	75.64%	60.93%	67.16%
2 Years	73.00%	52.10%	50.46%	67.19%	69.57%	72.62%	80.47%	41.38%	76.11%	78.00%	66.09%	71.52%
3 Years	64.89%	52.70%	42.40%	59.43%	71.01%	48.97%	65.67%	55.05%	67.19%	74.63%	60.19%	63.59%
Total	68.03%	51.50%	44.25%	60.94%	71.29%	54.27%	68.97%	52.67%	70.14%	75.70%	61.78%	66.02%

[1] Lower rate indicates better performance for the Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits.

BH-MCO Performance Measures

PA's HealthChoices BH program does not require BH-MCOs to complete a HEDIS Compliance Audit. BH-MCOs and Primary Contractors are required to calculate PAPMs, which are validated annually by IPRO, to support the MCOs' QAPI Program requirements. For MY 2021, these performance measures were: Follow-up After Hospitalization for Mental Illness (FUH, both HEDIS and PA-specific) and Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA).

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2018 (MY 2017), in part to better account for the growing population of members 65+ years, OMHSAS changed its benchmarking to the FUH All Ages (6+ years) measure. OMHSAS established a three-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more proactive

approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 Statewide BBA report. Due to this change in the goal-setting method, no goals were set for MY 2018. Among the updates in 2019 (MY 2018), NCQA added the following reporting strata for FUH, ages: 6-17, 18-64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are now broken into ages: 6-17, 18-64, and 6 and over (All Ages). HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH MCO to complete and submit an RCA and QIP.

To incentivize improvements in its PA PMs, OMHSAS launched in 2020 a P4P program for the HEDIS FUH All Ages and REA measures that determines payments based on performance with respect to certain benchmarks and to improvement over prior year.

MY 2021 performance measure results are presented in **Table 8** for each BH-MCO, along with the BH MMC average and BH MMC weighted average, which takes into account the proportional relevance of each MCO.

Table 8: BH-MCO Results for 2022 (MY 2021) PAPMs

BH-MCO Performance Measure	BHO	CBH	CCBH	MBH	PerformCare	BH MMC Average	BH MMC Weighted Average
HEDIS Follow-up After Hospitalization for Mental Illness							
Within 7 Days – Ages 6-17	57.6%	45.4%	56.4%	42.0%	51.9%	50.7%	52.3%
Within 30 Days – Ages 6-17	82.9%	61.6%	79.5%	69.9%	76.4%	74.0%	75.9%
Within 7 Days – Ages 18-64	39.6%	19.4%	40.1%	34.1%	31.9%	33.0%	34.3%
Within 30 Days – Ages 18-64	61.5%	34.4%	60.3%	54.2%	52.5%	52.6%	53.7%
Within 7 Days – All Ages	43.8%	22.8%	43.3%	35.6%	36.1%	36.3%	37.7%
Within 30 Days – All Ages	66.3%	37.9%	64.0%	57.1%	57.5%	56.6%	57.9%
Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness							
Within 7 Days – All Ages	51.8%	39.3%	53.6%	46.2%	46.7%	47.5%	48.8%
Within 30 Days – All Ages	71.7%	54.1%	70.7%	62.0%	65.6%	64.8%	65.9%
Readmission Within 30 Days of Inpatient Psychiatric Discharge							
Within 30 Days – All Ages	13.1%	14.9%	12.4%	14.0%	12.9%	13.4%	13.2%

- The BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for both the HEDIS FUH 7- and 30-day All-Ages measures were between the HEDIS 33rd and 50th percentiles. Consequently, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for ages 6+ for both 7- and 30-day rates was not achieved. The Primary Contractors that met or exceeded the 75th percentile on at least one of the two measures were: Bedford-Somerset, Blair, Franklin-Fulton, and Southwest Behavioral Health Management.
- None of the BH-MCOs met the OMHSAS performance goal of 11.75% (or lower) for REA.

CHC-MCO Performance Measures

Each CHC-MCO underwent a full HEDIS Compliance Audit in MY2021. The CHC-MCOs are required by DHS to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the *HEDIS MY 2021: Volume 2: Technical Specifications*. All the CHC-MCO HEDIS rates are compiled and provided to DHS on an annual basis. IPRO validated all performance measures reported by each MCO for MY 2021 to ensure that the performance measures were implemented to specifications and state reporting requirements (42 C.F.R. § 438.330(b)(2). **Table 9a** represents the HEDIS performance for all four CHC-MCOs in 2022, as well as the CHC MMC mean and the CHC MMC weighted average. The PA DHS Mean does not include measures with denominators less than 30. The CHC MMC Average is a weighted average, which is an average that considers the proportional relevance of each MCO, and therefore includes measures with denominators less than 30.

Comparisons to fee-for-service Medicaid data are not included in this report as the fee-for-service data and processes were not subject to a HEDIS compliance audit for HEDIS MY 2021 measures.

Table 9a, below, summarizes the CHC-MCOs' 2022 (MY 2021) HEDIS performance measure results, with noteworthy findings listed underneath the table.

Table 9a: CHC-MCO Performance Measure Results for 2022 (MY 2021) using HEDIS Technical Specifications

CHC-MCO HEDIS Measures	ACP CHC	KF CHC	PAHW CHC	UPMC CHC	PA DHS Mean	Weighted Average
Effectiveness of Care						
Prevention and Screening						
Breast Cancer Screening (BCS)						
BCS: Rate	54.98%	58.5%	44.82%	63.95%	55.56%	60.27%
Cervical Cancer Screening (CCS)						
CCS: Rate	39.66%	53.53%	31.14%	53.28%	44.40%	49.50%
Chlamydia Screening in Women (CHL)						
CHL: Ages 21-24 Years	16.67%[1]	36.67%	50%[1]	42.42%	39.55%	40.62%
CHL: Total Rate	16.67%[1]	36.67%	50%[1]	42.42%	39.55%	40.62%
Care for Older Adults (COA)						
COA: Advance Care Planning	28.71%	33.09%	48.42%	60.1%	42.58%	51.60%
COA: Medication Review	85.40%	91.73%	88.81%	86.13%	88.02%	87.76%
COA: Functional Status Assessment	45.99%	53.28%	57.18%	72.75%	57.30%	65.76%
COA: Pain Assessment	87.83%	91.48%	66.42%	86.62%	83.09%	85.66%
Respiratory Conditions						
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)						
SPR: Ages 21-24 Years	5.88%[1]	24.68%	15.84%	24.65%	21.72%	23.99%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
PCE: Systemic Corticosteroid	73.81%	76.09%	72.99%	79.06%	75.49%	77.03%
PCE: Bronchodilator	89.05%	94.05%	91.32%	88.93%	90.84%	90.79%

CHC-MCO HEDIS Measures	ACP CHC	KF CHC	PAHW CHC	UPMC CHC	PA DHS Mean	Weighted Average
Asthma Medication Ratio (AMR)						
AMR: 19-50 Years	64.52%	55.82%	63.74%	71.43%	63.88%	63.30%
AMR: 51-64 Years	58.82%	47.16%	49.04%	66.46%	55.37%	52.88%
AMR: Total Rate	61.22%	49.86%	54.44%	68.84%	58.59%	56.79%
Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)						
CBP: Total Rate	72.75%	61.56%	50.61%	74.94%	64.97%	67.60%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)						
PBH: Total Rate	100%[1]	95.12%	91.30%[1]	93.48%	94.30%	94.25%
Statin Therapy for Patients With Cardiovascular Disease (SPC)						
SPC: Received Statin Therapy - 21-75 Years (Male)	91.07%	89.58%	83.01%	86.25%	87.48%	86.91%
SPC: Received Statin Therapy - 40-75 Years (Female)	89.02%	88.4%	85.71%	81.14%	86.07%	84.12%
SPC: Received Statin Therapy - Total Rate	89.86%	88.91%	84.42%	83.52%	86.68%	85.39%
SPC: Statin Adherence 80% - 21-75 Years (Male)	70.59%	80.94%	78.95%	86.33%	79.20%	83.42%
SPC: Statin Adherence 80% - 40-75 Years (Female)	84.93%	80.42%	82.81%	87.88%	84.01%	84.85%
SPC: Statin Adherence 80% - Total Rate	79.03%	80.65%	80.99%	87.13%	81.95%	84.19%
Diabetes						
Comprehensive Diabetes Care (CDC)						
CDC: HbA1c Testing	91%	87.83%	83.21%	91.73%	88.44%	89.30%
CDC: HbA1c Poor Control (> 9.0%)	34.79%	34.55%	49.64%	29.2%	37.05%	33.96%
CDC: HbA1c Control (< 8.0%)	52.8%	53.28%	42.34%	62.77%	52.80%	56.28%
CDC: Eye Exam	53.53%	53.77%	48.42%	74.21%	57.48%	62.54%
CDC: Blood Pressure Controlled (< 140/90 mmHg)	67.40%	54.50%	50.85%	70.32%	60.77%	62.33%
Statin Therapy for Patients with Diabetes (SPD)						
SPD: Received Statin Therapy	79.30%	79.14%	75.46%	77.7%	77.90%	78.02%
SPD: Statin Adherence 80%	79.79%	78.07%	79.94%	85.84%	80.91%	81.95%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
AMM: Effective Acute Phase Treatment	73.74%	66.9%	80.86	72.97%	73.62%	72.60%
AMM: Effective Continuation Phase Treatment	63.13%	52.41%	71.49%	60.36%	61.85%	60.12%
Diabetes Screening For People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)						
SSD: Total Rate	89.81%	84.23%	82.18%	83.76%	85.00%	83.92%

CHC-MCO HEDIS Measures	ACP CHC	KF CHC	PAHW CHC	UPMC CHC	PA DHS Mean	Weighted Average
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)						
SMD: Total Rate	59.04%	69.58%	61.11%	76.45%	66.55%	70.69%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)						
SMC: Total Rate	42.86%[1]	69.05%	68.00%[1]	75.61%	72.33%	73.39%
Pharmacotherapy for Opioid Use Disorder (POD)						
POD: Ages 16-64 Years	23.08%[1]	26.87%	37.70%	49.19%	37.92%	42.68%
POD: Ages 65+ Years[1]	100.00%[1]	66.67%[1]	62.50%[1]	59.38%	72.15%	61.29%
POD: Total Rate	28.57%[1]	30.14%	42.86%	50.69%	41.23%	45.22%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)						
SAA: Total Rate	85.62%	70.63%	74.22%	84.95%	78.86%	80.16%
Overuse/Appropriateness						
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
AAB: 18-64 Years	86.67%	56.84%	55.17%[1]	33.11%	44.98%	42.27%
AAB: 65+ Years	66.67%	59.09%[1]	33.33%[1]	23.08%	45.55%	65.06%
AAB: Total Rate	83.33%	57.26%	51.43%	30.54%	46.41%	41.41%
Use of Imaging Studies for Low Back Pain (LBP)						
LBP: Total Rate	79.55%	82.82%	71.7%	76.67%	77.69%	78.30%
Use of Opioids at High Dosage (HDO)						
HDO: Total Rate	11.52%	14.6%	11.64%	8.82%	11.65%	10.58%
Use of Opioids From Multiple Providers (UOP)						
UOP: Multiple Prescribers	15.24%	13.6%	12.64%	17.57%	14.76%	16.07%
UOP: Multiple Pharmacies	1.87%	1.52%	0.92%	2.1%	1.60%	1.84%
UOP: Multiple Prescribers and Multiple Pharmacies	1.07%	0.79%	0.41%	1.09%	0.84%	0.96%
Risk of Continued Opioid Use (COU)						
COU: 18-64 Years - ≥ 15 Days Covered	4.86%	9.48%	22.09%	13.98%	12.60%	13.10%
COU: 65+ Years - ≥ 15 Days Covered	6.45%	12.47%	28.63%	20.05%	16.90%	19.19%
COU: Total Rate - ≥ 15 Days Covered	5.05%	9.99%	23.47%	15.89%	13.60%	14.62%
COU: 18-64 Years - ≥ 31 Days Covered	4.19%	7.11%	19.15%	8.58%	9.76%	9.32%
COU: 65+ Years - ≥ 31 Days Covered	0%	8.13%	24.23%	10.93%	10.82%	11.59%
COU: Total Rate - ≥ 31 Days Covered	3.69%	7.28%	20.22%	9.32%	10.13%	9.89%
Medication Management						
Transition of Care (TRC)						
TRC: Notification of Inpatient Admission	1.22%	1.46%	11.68%	51.34%	16.43%	33.81%

CHC-MCO HEDIS Measures	ACP CHC	KF CHC	PAHW CHC	UPMC CHC	PA DHS Mean	Weighted Average
TRC: Receipt of Discharge Information	0.30%	0.97%	9.49%	45.26%	14.01%	29.62%
TRC: Patient Engagement After Inpatient Discharge	82.07%	80.05%	80.78%	89.54%	83.11%	86.13%
TRC: Medication Reconciliation Post-Discharge	66.87%	73.24%	36.01%	73.72%	62.46%	69.24%
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
AAP: Ages 20-44 Years	94.29%	89.49%	88.24%	94.33%	91.59%	91.90%
AAP: Ages 45-64 Years	98.34%	95.68%	93.58%	97.75%	96.34%	96.53%
AAP: Ages 65+ Years	96.24%	95.34%	91.22%	96.85%	94.91%	95.82%
AAP: Total Rate	97.05%	94.61%	91.91%	96.9%	95.12%	95.57%
Long-Term Services and Supports						
Comprehensive Assessment and Update (CAU)						
CAU: Assessment of Core Elements	86.84%	86.84%	52.08%	88.5%	78.57%	79.24%
CAU: Assessment of Supplemental Elements	86.84%	86.84%	52.08%	88.5%	78.57%	79.24%
Comprehensive Care Plan and Update (CPU)						
CPU: Care Plan with Core Elements Documented	92.98%	92.11%	55.21%	63.72%	76.01%	75.80%
CPU: Care Plan with Supplemental Elements Documented	92.98%	92.11%	55.21%	63.72%	76.01%	75.80%
Reassessment/Care Plan Update After Inpatient Discharge (RAC)						
RAC: Reassessment After Inpatient Discharge	32.14%	27.27%	41.67%	32.29%	33.34%	33.56%
RAC: Reassessment and Care Plan Update After Inpatient Discharge	32.14%	25.45%	36.46%	17.71%	27.94%	25.59%
Shared Care Plan with Primary Care Practitioner (SCP)						
SCP: Total Rate	80.87%	71.3%	45.83%	54.31%	63.08%	62.24%
Utilization and Risk Adjusted Utilization						
Utilization						
Frequency of Selected Procedures (FSP)[1]						
FSP: Bariatric Weight Loss Surgery - 20-44 Years - M	0.00	0.08	0.09	0.03	0.05	
FSP: Bariatric Weight Loss Surgery - 20-44 Years - F	0.00	0.48	0.18	0.48	0.29	
FSP: Bariatric Weight Loss Surgery - 45-64 Years - M	0.07	0.08	0.00	0.07	0.06	
FSP: Bariatric Weight Loss Surgery - 45-64 Years - F	0.17	0.26	0.19	0.18	0.20	
FSP: Hysterectomy - Abdominal - 15-44 Years - F	0.00	0.16	0.09	0.14	0.10	
FSP: Hysterectomy - Abdominal - 45-64 Years - F	0.17	0.11	0.05	0.06	0.10	
FSP: Hysterectomy - Vaginal - 15-44 Years - F	0.15	0.12	0.09	0.17	0.13	
FSP: Hysterectomy - Vaginal - 45-64 Years - F	0.04	0.06	0.08	0.05	0.06	
FSP: Cholecystectomy - Open - 30-64 Years - M	0.05	0.06	0.03	0.05	0.05	

CHC-MCO HEDIS Measures	ACP CHC	KF CHC	PAHW CHC	UPMC CHC	PA DHS Mean	Weighted Average
FSP: Cholecystectomy - Open - 15-44 Years - F	0.00	0.04	0.00	0.00	0.01	
FSP: Cholecystectomy - Open - 45-64 Years - F	0.08	0.09	0.05	0.06	0.07	
FSP: Cholecystectomy - Laparoscopic - 30-64 Years - M	0.32	0.11	0.24	0.36	0.26	
FSP: Cholecystectomy - Laparoscopic - 15-44 Years - F	0.89	0.24	0.64	0.59	0.59	
FSP: Cholecystectomy - Laparoscopic - 45-64 Years - F	0.58	0.34	0.33	0.50	0.44	
FSP: Back Surgery - 20-44 Years - M	0.60	0.42	0.45	0.16	0.41	
FSP: Back Surgery - 20-44 Years - F	0.30	0.24	0.36	0.42	0.33	
FSP: Back Surgery - 45-64 Years - M	0.49	0.67	0.70	0.82	0.67	
FSP: Back Surgery - 45-64 Years - F	0.79	0.51	0.49	1.09	0.72	
FSP: Mastectomy - 15-44 Years - F	0.00	0.08	0.00	0.06	0.04	
FSP: Mastectomy - 45-64 Years - F	0.08	0.15	0.05	0.04	0.08	
FSP: Lumpectomy - 15-44 Years - F	0.00	0.24	0.00	0.17	0.10	
FSP: Lumpectomy - 45-64 Years - F	0.37	0.28	0.30	0.27	0.31	
Ambulatory Care: Total (AMBA)[1]						
AMBA: Outpatient Visits	1027.76	859.72	762.48	1110.29	940.06	981.04
AMBA: Emergency Department Visits	89.14	82.27	76.46	82.6	82.62	82.17
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)[1]						
IPUA: Total Discharges	33.77	41.77	31.4	25.56	33.13	
Antibiotic Utilization: Total (ABXA)						
ABXA: Total Antibiotic Scrips	9199	30533	12606	73893	31557.75	
ABXA: Average Scrips PMPY for Antibiotics	1.66	1.22	1.24	1.91	1.5075	
ABXA: Total Number of Scrips for Antibiotics of Concern	3927	12709	5216	33253	13776.25	
ABXA: Average Scrips PMPY for Antibiotics of Concern	0.71	0.51	0.51	0.86	0.6475	
Risk Adjusted Utilization						
Plan All-Cause Readmissions (PCR)						
PCR: Count of Index Stays (Ages 18-44 Years)	135.00	624.00	296.00	334.00	347.25	
PCR: Count of Index Stays (Ages 45-54 Years)	183.00	913.00	372.00	523.00	497.75	
PCR: Count of Index Stays (Ages 55-64 Years)	421.00	1825.00	860.00	1128.00	1058.50	
PCR: Count of Index Stays (Ages Total)	739.00	3362.00	1528.00	1985.00	1903.50	
PCR: Count of Observed 30-Day Readmissions (Ages 18-44 Years)	23.00	104.00	39.00	30.00	49.00	
PCR: Count of Observed 30-Day Readmissions (Ages 45-54 Years)	27.00	135.00	58.00	56.00	69.00	
PCR: Count of Observed 30-Day Readmissions (Ages 55-64 Years)	69.00	263.00	110.00	125.00	141.75	
PCR: Count of Observed 30-Day Readmissions (Ages Total)	119.00	502.00	207.00	211.00	259.75	

CHC-MCO HEDIS Measures	ACP CHC	KF CHC	PAHW CHC	UPMC CHC	PA DHS Mean	Weighted Average
PCR: Count of Expected 30-Day Readmissions (Ages 18-44 Years)	16.17	71.20	35.20	38.95	40.38	
PCR: Count of Expected 30-Day Readmissions (Ages 45-54 Years)	25.29	107.45	48.81	64.49	61.51	
PCR: Count of Expected 30-Day Readmissions (Ages 55-64 Years)	65.09	246.70	125.01	155.39	148.05	
PCR: Count of Expected 30-Day Readmissions (Ages Total)	106.55	425.35	209.02	258.83	249.94	
PCR: Observed Readmission Rate (Ages 18-44 Years)	17.04	16.67	13.18	8.98	13.97	
PCR: Observed Readmission Rate (Ages 45-54 Years)	14.75	14.79	15.59	10.71	13.96	
PCR: Observed Readmission Rate (Ages 55-64 Years)	16.39	14.41	12.79	11.08	13.67	
PCR: Observed Readmission Rate (Ages Total)	16.10	14.93	13.55	10.63	13.80	
PCR: Expected Readmission Rate (Ages 18-44 Years)	11.98	11.41	11.89	11.66	11.74	
PCR: Expected Readmission Rate (Ages 45-54 Years)	13.82	11.77	13.12	12.33	12.76	
PCR: Expected Readmission Rate (Ages 55-64 Years)	15.46	13.52	14.54	13.78	14.33	
PCR: Expected Readmission Rate (Ages Total)	14.42	12.65	13.68	13.04	13.45	
PCR: Observed to Expected Readmission Ratio (Ages Total)	1.12	1.18	0.99	0.82	1.03	

[1]Eligible population for the measure was <30. Results should be interpreted with caution.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; CHC: Community HealthChoices; MCO: managed care organization; ACP: AmeriHealth Caritas Pennsylvania; KF: Keystone First; PAHW: Pennsylvania Health and Wellness; UPMC: UPMC Health Plan; PA DHS: Pennsylvania Department of Human Services.

In addition to HEDIS, CHC-MCOs are required to calculate PAPMs, which are validated by IPRO on an annual basis.

Results for PAPMs are presented for each CHC-MCO in **Table 9b**, along with the CHC average and CHC weighted average, which takes into account the proportional relevance of each MCO.

Table 9b: CHC-MCO Results for 2022 (MY 2021) PAPMs

CHC-MCO PA-PM	ACP CHC	KF CHC	PAHW CHC	UPMC CHC	PA DHS Mean	Weighted Average
Adults' Annual Dental Visit (AADV)						
AADV: Total Rate	20.61%	26.20%	15.06%	20.12%	20.50%	20.44%

Section III: Compliance with Medicaid and CHIP Managed Care Regulations

This section of the EQR report presents a review by IPRO of the PH-, BH-, CHIP-, and CHC-MCOs with regard to compliance with state and federal regulations. The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the subparts set out in the BBA regulations that were updated in 2016 and again in late 2019. These requirements are described in the CMS EQR Protocol: Review of Compliance with Medicaid and CHIP Managed Care Regulations. Summaries of methodological evaluations of compliance are further described in these programs' subsections, below.

Following the summaries in each programs' subsection, tabulated findings are formatted to be consistent with the subparts prescribed by the BBA regulations. Applicable regulatory requirements are summarized under each programs' subsections, consistent with the applicable subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol.* Under each program's subsection are the individual regulatory categories appropriate to that program.

Evaluation of PH-MCO Compliance

For the PH Medicaid MCOs, the information for the compliance with state and federal regulations section of the report is derived from the OMAP's monitoring of the MCOs against the SMART standards, from additional monitoring activities outlined by DHS staff, from the HealthChoices Agreement, and from National Committee for Quality Assurance (NCQA™) accreditation results.

The SMART Items provide much of the information necessary for each PH-MCO's review. The SMART Items are a comprehensive set of monitoring items that the DHS staff reviews on an ongoing basis for each PH-MCO. These items vary in review periodicity as determined by DHS and reviews typically occur annually or as needed. Additionally, reviewers have the option to review individual zones covered by an MCO separately, and to provide multiple findings within a year (e.g., quarterly). Within the SMART system there is a mechanism to include review details, where comments can be added to explain the MCO's compliance, partial compliance, or non-compliance. There is a year allotted to complete all of the SMART standards; if an MCO is non-compliant or partially compliant, this time is built into the system to prevent a Standard from being "finalized." If an MCO does not address a compliance issue, DHS would discuss as a next step the option to issue a Work Plan, a Performance Improvement Plan, or a Corrective Action Plan (CAP). Any of these next steps would be communicated via formal email communications with the MCO. Per DHS, MCOs usually address the issues in SMART without the necessity for any of these actions, based on the SMART timeline.

IPRO reviewed the elements in the SMART Item List and created a crosswalk to pertinent BBA regulations. The SMART Items did not directly address two categories: Cost Sharing and Effectuation of Reversed Resolutions. Cost Sharing is addressed in the HealthChoices Agreement. Effectuation of Reversed Resolutions is evaluated as part of the most recent NCQA Accreditation review under Utilization Management (UM) Standard 8: Policies for Appeals and UM 9: Appropriate Handling of Appeals. A total of 135 unique SMART Items were identified that were relevant to evaluation of PH-MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS. The SMART Items from Review Year (RY) 2021, RY 2020, and RY 2019 provided the information necessary for this assessment.

The crosswalk linked SMART Items to specific provisions of the regulations, where possible. Some items were relevant to more than one provision. The most recently revised CMS protocols included updates to the structure and compliance standards, including which standards are required for compliance review. Under these protocols, there are 11 standards that CMS has designated as required to be subject to compliance review. Several previously required standards have been deemed by CMS as incorporated into the compliance review through interaction with the new required standards and appear to assess items that are related to the required standards. The compliance evaluation was conducted on the crosswalked regulations for all 11 required standards and remaining related standards that were previously required and continue to be reviewed.

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO's compliance status with regard to the SMART Items. For example, all provisions relating to availability of services are summarized under Availability of Services §438.206. This grouping process was done by referring to CMS's "Regulations Subject to Compliance Review," where specific Medicaid regulations are noted as required for review and corresponding sections are identified and described for each Subpart, particularly D and E. Comprehensive findings for standards that were reviewed either directly through one of the 11 required standards below or indirectly through interaction with Subparts D and E can be found in each MCO's 2022 External Quality Review Report. Each Item was assigned a value of compliant or not compliant in the Item Log submitted by the OMAP. If an Item was not evaluated for a particular MCO, it was assigned a value of not determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category. If all Items were compliant, the MCO was evaluated as compliant. If some were compliant and some were not compliant, the MCO was evaluated as partially compliant. If all Items were not compliant, the MCO was evaluated as not compliant. For categories where Items were not evaluated, under review, or received an approved waiver for RY 2021, results from reviews conducted within the two prior review years (RY 2020 and RY 2019) were evaluated to determine compliance. If no Items were evaluated for a given category and no other source of information was available to determine compliance over the three-year period, a value of not determined was assigned for that specific category.

Tables 10a and **10b** summarize compliance assessments for state and federal regulations across MCOs. Across MCOs, there were no categories determined to be partially- or non-Compliant, signifying that no SMART Items were assigned a value of non-Compliant by DHS. **There are therefore no recommendations related to compliance with state and federal regulations for any PH-MCO for the current review year.**

Table 10a: PH-MCO Compliance with Subpart D – MCO, PIHP and PAHP Standards Regulations

Subpart D: MCO, PIHP and PAHP Standards	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
Availability of Services	C	C	C	C	C	C	C	C	C
Assurances of Adequate Capacity and Services	C	C	C	C	C	C	C	C	C
Coordination and Continuity of Care	C	C	C	C	C	C	C	C	C
Coverage and Authorization of Services	C	C	C	C	C	C	C	C	C
Provider Selection	C	C	C	C	C	C	C	C	C
Confidentiality	C	C	C	C	C	C	C	C	C
Enrollment and Disenrollment	C	C	C	C	C	C	C	C	C
Grievance and Appeal System	C	C	C	C	C	C	C	C	C
Subcontractual Relationships and Delegations	C	C	C	C	C	C	C	C	C
Practice Guidelines	C	C	C	C	C	C	C	C	C
Health Information Systems	C	C	C	C	P	C	C	C	P

- Each PH-MCO was compliant for 9 categories of MCO, PIHP and PAHP Standards Regulations: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal System, Subcontractual Relationships and Delegations, and Practice Guidelines. One MCO was partially compliant for Health Information Systems.

Table 10b: PH-MCO Compliance with Subpart E – Quality Measurement and Improvement; External Quality Review Regulations

Subpart E: Quality Measurement and Improvement	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
Quality Assessment and Performance Improvement Program (QAPI)	C	C	C	C	C	C	C	C	C

- Each PH-MCO was compliant for the required Quality Assessment and Performance Improvement Program category for RY 2021.

Evaluation of CHIP-MCO Compliance

For the CHIP MCOs, the information for the compliance with state and federal regulations section of the report is derived from the CHIP's monitoring of the MCOs against the SMART standards. The review is based on information derived from reviews of the MCO that were conducted by PA CHIP within the past three years, most typically within the immediately preceding year. Compliance reviews are conducted by CHIP on a recurring basis.

Prior to the audit, CHIP MCOs provide documents to CHIP for review, which address various areas of compliance. This includes training materials, provider manuals, MCO organization charts, policy and procedure manuals, and geo access maps. These items are also used to assess the MCOs overall operational, fiscal, and programmatic activities to ensure compliance with contractual obligations. Federal and state law require that CHIP conduct monitoring and oversight of its MCOs. For the current review year, reviews were performed virtually due to the public health emergency. Throughout the audit, these areas of compliance are discussed with the MCO and clarifying information is provided, where possible. Discussions that occur are compiled along with the reviewed documentation to provide a final determination of compliance, partial compliance, or non-compliance for each section.

The SMART Items provide the information necessary for each CHIP-MCO's review. The SMART Items are a comprehensive set of monitoring items that the DHS CHIP staff review on an ongoing basis for each CHIP-MCO. IPRO reviewed the elements in the SMART Item List and created a crosswalk to pertinent BBA regulations. A total of 56 unique SMART Items were identified that were relevant to the evaluation of CHIP-MCO compliance with the BBA regulations. These Items vary in review periodicity from annually, semiannually, quarterly, monthly, or as needed. The SMART Items from Review Year (RY) 2021 provided the information necessary for this assessment for two MCOs, Aetna Better Health and Health Partners Plan. The remaining MCOs did not have a review completed during this review year, and in these cases RY 2020's results were used in reporting for 2022.

To evaluate CHIP-MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCOs' compliance status with regard to these SMART Items. For example, all provisions relating to service availability are summarized under Availability of Services 457.1230(a). Each Item was assigned a value of compliant or not compliant in the Item Log submitted by CHIP. If an Item was not evaluated for a particular MCO, it was assigned a value of not determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category. If all Items were compliant, the MCO was evaluated as compliant. If some were compliant and some were not compliant, the MCO was evaluated as partially compliant. If all Items were not compliant, the MCO was evaluated as not compliant. If no Items were evaluated for a given category and no other source of information was available to determine compliance over the evaluation period, a value of not determined was assigned for that specific category.

56 Items were directly associated with a regulation subject to compliance review and were evaluated for the MCO in Review Year (RY) 2021. These items fall under Subpart D: MCO, PIHP and PAHP Standards and Subpart E: Quality Measurement and Improvement. The general purpose of the regulations included under Subpart D is to ensure that all services covered under the DHS's CHIP program are available and accessible to MCO enrollees. [42 C.F.R. § 438.206 (a)] The general purpose

of the regulations included under Subpart E is to ensure that each contracting MCO implements and maintains a quality assessment and performance improvement program as required by the State. This includes implementing an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees.

Tables 11a and **11b** summarize compliance assessments for state and federal regulations across MCOs. Across MCOs, there were no categories determined to be partially- or non-Compliant, signifying that no SMART Items were assigned a value of non-Compliant by DHS. **There are therefore no recommendations related to compliance with state and federal regulations for any CHIP-MCO for the current review year.**

Table 11a: CHIP-MCO Compliance with Subpart D – MCO, PIHP and PAHP Standards Regulations

Subpart D: MCO, PIHP and PAHP Standards	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	IBC	NEPA	UHC	UPMC	TOTAL CHIP MMC
Availability of services	C	C	C	C	C	C	C	C	C	C	C
Assurances of adequate capacity and services	C	C	C	C	C	C	C	C	C	C	C
Coordination and continuity of care	C	C	C	C	C	C	C	C	C	C	C
Coverage and authorization of services	C	C	C	C	C	C	C	C	C	C	C
Provider selection	C	C	C	C	C	C	C	C	C	C	C
Confidentiality	C	C	C	C	C	C	C	C	C	C	C
Grievance systems[1]	C	C	C	C	C	C	C	C	C	C	C
Subcontractual relationships and delegation	C	C	C	C	C	C	C	C	C	C	C
Practice guidelines	C	C	C	C	C	C	C	C	C	C	C
Health information systems	C	C	C	C	C	C	C	C	C	C	C

[1] Per CMS guidelines and protocols, this regulation is typically referred to as "Grievance and appeals systems." However, to better align with the CHIP reference for 457.1260, it is referred to in this report as "Grievance systems."

- Each CHIP-MCO that underwent review in RY 2021 was compliant for all 10 categories of MCO, PIHP and PAHP Standards Regulations: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegations, Practice Guidelines, and Health Information Systems.
- As noted above, CBC, GEI, Highmark HMO, Highmark PPO, IBC, NEPA, UHC, and UPMC did not undergo review during RY 2021. Their compliance results from RY 2020 are reflected in Table 11a above.

Table 11b: CHIP-MCO Compliance with Subpart E – Quality Measurement and Improvement; External Quality Review Regulations

Subpart E: Quality Measurement and Improvement	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	IBC	NEPA	UHC	UPMC	TOTAL CHIP MMC
Quality assessment and performance improvement program	C	C	C	C	C	C	C	C	C	C	C

- Each CHIP-MCO that underwent review was compliant for the required Quality Assessment and Performance Improvement Program category for RY 2021.
- As noted above, CBC, GEI, Highmark HMO, Highmark PPO, IBC, NEPA, UHC, and UPMC did not undergo review during RY 2021. Their compliance results from RY 2020 are reflected in Table 11b above.

Evaluation of BH-MCO Compliance

For BH-MCOs, the information is derived from monitoring conducted by OMHSAS against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application for both BH-MCOs and contracted HealthChoices Oversight Entities. As necessary, the HealthChoices BH PS&R and Readiness Assessment Instrument (RAI) are also used.

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of BH-MCOs by OMHSAS monitoring staff within the past three review years (RYs 2021, 2020, 2019). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS' PEPS Review Application for RY 2021. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year time frame under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year time frame, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's PS&R Agreement is also used. In 2019, Bedford-Somerset moved its contract from PerformCare to CCBH. If a county is contracted with more than one BH-MCO in the review period, compliance findings for that county are not included in the BBA reporting for either BH-MCO for a three-year period.

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2021 and entered into the PEPS Application as of March 2022 for RY 2021. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the Substandards or "Items" for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the PEPS Application, a HealthChoices Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS' more rigorous monitoring criteria.

Because OMHSAS' review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS substandards from RY 2021, RY 2020, and RY 2019 provided the information necessary for the 2021 assessment. Those standards not reviewed through the PEPS system in RY 2021 were evaluated on their performance based on RY 2020 and/or RY 2019 determinations, or other supporting documentation, if necessary. From time-to-time standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating three-year schedule for all five BH-MCOs. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year time frame under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

The format chosen here to present findings related to BH-MCO compliance with MMC regulations follows the structure described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[6] Under each general section heading are the regulatory categories requiring reporting. Findings

for the BH-MCOs are therefore organized under "Standards, including Enrollee Rights and Protections," "Quality Assessment and Performance Improvement (QAPI) Program," and "Grievance System." Note that under the new CMS review structure, some categories now provide for interaction across Subparts. The standards that are subject to EQR review are contained in 42 C.F.R. 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E.

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision ("category") and evaluated the Primary Contractors' and BH-MCOs' compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met, or not met in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HealthChoices Oversight Entity/BH-MCO, it was assigned a value of not determined. Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the PEPS substandards linked to each provision. If all substandard items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as not compliant. If no crosswalked items were evaluated for a given provision, and no other source of information was available to determine compliance, a value of not applicable (N/A) was assigned for that provision. A value of null was assigned to a provision when none of the existing PEPS Substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. **Table 12a, 12b,** and **12c** summarize compliance assessments across MCOs.

Table 12a: BH-MCO Compliance with Standards, Including Enrollee Rights and Protections

Standards, including enrollee rights and protections	BHO	CBH	CCBH	MBH	PerformCare	TOTAL BH MMC
Assurances of adequate capacity and services	P	C	C	C	C	P
Availability of services	P	P	P	C	P	P
Confidentiality	C	C	C	C	C	C
Coordination and continuity of care	P	P	P	C	P	P
Coverage and authorization of services	P	P	P	P	P	P
Health information systems	C	C	C	C	C	C
Practice guidelines	P	P	P	C	P	P
Provider selection	C	P	C	C	C	P
Subcontractual relationships and delegation	C	C	C	C	C	C

Note: The BH-MCO compliance determination represents the aggregate status of multiple HealthChoices Oversight Entities/Primary Contractors (e.g., if seven Primary Contractors contract with a BH-MCO, and a standard has 10 items, partial compliance on any one of the 70 items would generate an overall partial compliance status for the BH-MCO).

- Based on the total BH MMC score, the HealthChoices Behavioral Health program was compliant with 3 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations: Confidentiality, Health information systems, and Subcontractual relationships and delegation.
- Based on the total BH MMC score, the HealthChoices Behavioral Health program was partially compliant with 6 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations: Assurances of adequate capacity and services, Availability of services, Coordination of continuity of care, Coverage and authorization of services, Practice guidelines, and Subcontractual relationships and delegation.
- Individually, BHO was compliant with 4 of the 9 categories and partially compliant with 5 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, CBH was compliant with 4 of the 9 categories and partially compliant with 5 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, CCBH was compliant with 5 of the 9 categories and partially compliant with 4 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, MBH was compliant with 8 of the 9 categories and partially compliant with 1 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, PerformCare was compliant with 5 of the 9 categories and partially compliant with 4 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations

Table 12b: BH-MCO Compliance with Quality Assessment and Performance Improvement Program

Quality Assessment and Performance Improvement (QAPI) Program	BHO	CBH	CCBH	MBH	PerformCare	TOTAL BH MMC
Quality assessment and performance improvement program	P	C	C	C	C	P

Note: The BH-MCO compliance determination represents the aggregate status of multiple HealthChoices Oversight Entities/Primary Contractors (e.g., if seven Primary Contractors contract with a BH-MCO and a standard has 10 items, partial compliance on any one of the 70 items would generate an overall partial compliance status for the BH-MCO).

- Based on the total BH MMC score, the HealthChoices Behavioral Health program was partially compliant with Quality Assessment and Performance Improvement Program

Table 12c: BH-MCO Compliance with Grievance System

Grievance System	BHO	CBH	CCBH	MBH	PerformCare	TOTAL BH MMC
Grievance and appeal systems	P	P	P	P	P	P

Note: The BH-MCO compliance determination represents the aggregate status of multiple HealthChoices Oversight Entities/Primary Contractors (e.g., if seven Primary Contractors contract with a BH-MCO and a standard has 10 items, partial compliance on any one of the 70 items would generate an overall partial compliance status for the BH-MCO).

- Based on the total BH MMC score, the HealthChoices Behavioral Health program was partially compliant with Grievance System

Evaluation of CHC-MCO Compliance

This section of the EQR report presents a review of each CHC-MCO's compliance with state and federal regulations. The review is based on information derived from reviews of each CHC-MCO that were conducted by the Department within the past three years, most typically within the immediately preceding year. Compliance reviews are conducted by the Department on a recurring basis.

The SMART items are a comprehensive set of monitoring items that have been developed by the Department from the managed care regulations. The Department's staff reviews SMART items on an ongoing basis for each CHC-MCO as part of their compliance review. These items vary in review periodicity as determined by the Department and reviews typically occur annually or as needed.

Prior to the audit, CHC-MCOs provide documents to the Department for review, which address various areas of compliance. This documentation is also used to assess the CHC-MCOs overall operational, fiscal, and programmatic activities to ensure compliance with contractual obligations. Federal and state law require that the Department conduct monitoring and oversight of its CHC-MCOs.

The EQRO utilizes the SMART database findings as of the effective review year, per the following: the CHC Agreement, additional monitoring activities outlined by the Department, and the most recent NCQA Accreditation Survey for each CHC-MCO. Historically, regulatory requirements were grouped to corresponding BBA regulation subparts based on the Department's on-site review findings. Beginning in 2021, findings are reported by the EQRO using the SMART database completed by the Department's staff. The SMART items provide the information necessary for this review. The SMART items and their associated review findings for this year, which is the first year for CHC, are maintained in a database. The SMART database has been maintained internally at the Department starting with (RY) 2020 and will continue going forward for future review years. The EQRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 61 items were identified that were relevant to evaluation of CHC-MCO compliance with the BBA regulations.

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. The crosswalk links SMART items to specific provisions of the regulations, where possible. Items linked to each standard designated in the protocols as subject to compliance review were included either directly through one of the 11 required standards below, as presented in the below table, or indirectly through interaction with Subparts D and E.

Previously, the information necessary for the review was provided through an on-site review that was conducted by the Department. Beginning with the Department's adoption of the SMART database in 2020 for CHC, this database is now used to determine an MCO's compliance on individual provisions. This process was done by referring to CMS's "Regulations for Compliance Review," where specific CHC citations are noted as required for review and corresponding sections are identified and described for each Subpart, particularly D and E. The EQRO then grouped the monitoring standards by provision and evaluated each CHC-MCO's compliance status with regard to the SMART Items.

Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by the Department. If an item was not evaluated for a particular CHC-MCO, it was assigned a value of Not Determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category (as reflected in **Table 13**). If all items were Compliant, the CHC-MCO was evaluated as Compliant (C). If some were Compliant and some were non-Compliant, the CHC-MCO was evaluated as partially-Compliant (P). If all items were non-Compliant, the CHC-MCO was evaluated as non-Compliant (NC). If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined (ND) was assigned for that category.

Categories determined to be partially- or non-Compliant are indicated where applicable in the table below, and the SMART Items that were assigned a value of non-Compliant by the Department within those categories are noted. For the CHC-MCOs, there were no categories determined to be partially- or non-Compliant, signifying that the associated SMART Items were not assigned a value of non-Compliant by the Department.

Table 13: CHC-MCO Compliance with Subpart D (MCO, PIHP and PAHP Standards Regulations) and Subpart E (Quality Measurement and Improvement)

Subparts D and E	ACP CHC	KF CHC	PAHW	UPMC	TOTAL CHC MMC
Subpart D: MCO, PIHP and PAHP Standards					
Availability of services	C	C	C	C	C
Assurances of adequate capacity and services	C	C	C	C	C
Coordination and continuity of care	C	C	C	C	C
Coverage and authorization of services	C	C	C	C	C
Provider selection	C	C	C	C	C
Confidentiality	C	C	C	C	C
Grievance systems[1]	C	C	C	C	C
Subcontractual relationships and delegation	C	C	C	C	C
Practice guidelines	C	C	C	C	C
Health information systems	C	C	C	C	C
Subpart E: Quality Measurement and Improvement					
Quality assessment and performance improvement program[1]	C	C	C	C	C

[1] These items were evaluated in RY 2020. No update was available for RY 2021.

- Overall, the CHC-MCOs were found to be compliant across all applicable items directly associated with CFR Categories for Subparts D and E that were subject to review in RY 2021. Additionally, the CHC-MCOs were found to be compliant/without issue across the items that were indirectly associated with CFR Categories for Subparts D and E that were subject to review in RY 2021.

There are therefore no new recommendations related to compliance with CFR Categories for Subparts D and E for the CHC-MCOs.

Section IV: 2021 Opportunities for Improvement – MCO Response

To achieve full compliance with federal regulations, MCOs are requested to respond to each noted opportunity for improvement from the prior year's reports. For this year's report, the PH-MCOs, BH-MCOs, and CHIP-MCOs had previously identified opportunities for improvement and were requested to respond to the noted opportunities for improvement from the prior year's reports. The general purpose of this section of the report was to document the degree to which each MCO had addressed the opportunities for improvement made by IPRO in the 2021 EQR Technical Reports, which were distributed in April 2022. The 2022 EQR Technical Report is the 15th to include descriptions of current and proposed interventions considered by each MCO as applicable that address the prior year recommendations.

The PH-MCOs, BH-MCOs, CHIP-MCOs, and CHC-MCOs were required to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses were reported consistently across the Pennsylvania MCOs. Generally, the activities followed a longitudinal format and were designed to capture information related to:

- Follow-up actions that the MCOs had taken through June 30, 2022 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

PH-MCOs and BH-MCOs were also required to prepare a Root Cause Analysis and Action Plan for select performance measures noted as opportunities for improvement in the prior year's EQR Technical Report. For 2021, PH-MCOs were required to address those measures on the 2021 Pay for Performance (P4P) Measure Matrix receiving either D or F ratings, while BH-MCOs were required to address any FUH All-Ages rates that fell below the HEDIS (MY 2021) 75 percentile. These MCOs were required to submit the following for each underperforming measure:

- A goal statement,
- Root cause analysis and analysis findings,
- Action plan to address findings,
- Implementation dates, and
- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

Individual current and proposed interventions and applicable Root Cause Analysis and Action Plan for each PH-MCO, BH-MCO, and CHIP-MCOs are detailed in their respective annual technical reports. Corrective action plans that were in place at the OMHSAS level were also forwarded to IPRO to inform the BH-MCO 2022 annual technical reports.

Section V: 2022 Strengths and Opportunities for Improvement and EQR Recommendations

Overall Strengths

- All PH-MCOs were compliant on ten of the eleven State and Federal Regulations standards.
- All PH-MCOs successfully completed NCQA HEDIS Compliance Audits in 2022, and all PH-MCOs successfully calculated and completed validation of all PAPMs.
- All CHIP-MCOs successfully completed NCQA HEDIS Compliance Audits in 2022, and all CHIP-MCOs successfully calculated and completed validation of all PAPMs.
- All CHIP-MCOs were compliant on all eleven State and Federal Regulations standards.
- All five BH-MCOs successfully submitted Year 1 PIP reports.
- All five BH-MCOs successfully calculated and completed validation of Performance Measures related to Follow-up After Hospitalization for Mental Illness as well as Readmission Within 30 Days of Inpatient Psychiatric Discharge.
- All BH-MCOs were compliant with Confidentiality, Health information systems, and Subcontractual relationships and delegation.
- All PH-MCOs and BH-MCOs provided responses to the Opportunities for Improvements issued in the 2021 annual technical reports.
- All CHC-MCOs had compliance determinations for elements of Project Topic and Rationale, Aim Statement, Methodology, Barrier Analysis, Results Table, and Discussion that were sufficiently met for both PIP topics; however, compliance determinations for elements of Robust Interventions were partially met for the Transitions of Care from NF to the Community PIP for ACP/KF. For each CHC-MCOs' two PIPs, all scores based on the element determinations exceeded ≥ 85%.
- All CHC-MCOs completed NCQA HEDIS Compliance Audits in 2022 and had their Adult Medicaid CAHPS HP Survey sampling frames validated.
- All CHC-MCOs were found to be compliant across all applicable items directly associated with CFR Categories for Subparts D and E that were subject to review in RY 2021.

Overall Opportunities

- One PH-MCO was found to be partially compliant on one State and Federal Regulations standards, Health Information Systems.
- None of the BH-MCOs met the Quality Compass 75th percentile for the All-Ages/Overall (6+) HEDIS 7-Day Follow-up After Hospitalization for Mental Illness measure. None of the five BH-MCOs met the Quality Compass 75th percentile for the All-Ages/Overall (6+) HEDIS 30-Day FUH measure.
- None of the BH-MCOs achieved the OMHSAS goal of 11.75% or less for the Readmission Within 30 Days of Inpatient Psychiatric Discharge measure.
- All BH-MCOs were only partially compliant with 6 of the 9 categories of Standards, including Enrollee Rights and Protections
- All BH-MCOs were only partially compliant with Grievance System
- One parent CHC-MCO (ACP CHC/KF CHC) was found to have a continued issue with timely reporting per the submission schedule.
- Several of the CHC-MCOs (ACP CHC/KF CHC and UPMC CHC) did not properly report their eligible populations for the PA-specific performance measure, Adults' Annual Dental Visit.

Individual MCO strengths and opportunities are detailed in their respective annual technical reports.

Targeted opportunities for improvement were made for PH-MCOs and BH-MCOs regarding select measures via MCO-Specific Matrices or RCAs and QIPs. For PH-MCOs, each P4P Matrix provides a comparative look at selected measures and indicators included in the Quality Performance Measures component of the HealthChoices MCO Pay for Performance Program. The P4P Matrix indicates when an MCO's performance rates for the P4P measures are notable or whether

there is cause for action. Those measures that fall into the D and F graded categories require a root cause analysis and action plan to assist the MCOs with identifying factors contributing to poor performance.

Table 14 displays the P4P measures for each PH-MCO requiring a root cause analysis and action plan.

Table 14: PH-MCO Root Cause Analysis for 2022 (MY 2021) Measure Results

Rating	ABH	ACP	GEI	HPP	HWC	KF	UHC	UPMC
D	**Comprehensive Diabetes Care: HbA1c Poor Control**[4] **Postpartum Care** **Asthma Medication Ratio**	**Lead Screening in Children**	**Comprehensive Diabetes Care: HbA1c Poor Control**[4] **Postpartum Care** **Asthma Medication Ratio**		**Child and Adolescent Well-Care Visits (Ages 3—21 years)**[5]	**Comprehensive Diabetes Care: HbA1c Poor Control**[4] **Controlling High Blood Pressure** **Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)**[1] **Lead Screening in Children**	**Asthma Medication Ratio** **Lead Screening in Children**	
F	**Developmental Screening in the First Three Years of Life**[4] **Plan All Cause Readmissions**[2]	**Developmental Screening in the First Three Years of Life**	**Developmental Screening in the First Three Years of Life** **Plan All Cause Readmissions**[2]	**Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)**[1]				

[1] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaces Well-Child Visits in the First 15 Months of Life, 6 or more.
[2] Plan All Cause Readmissions was added as a P4P measure in 2022 (MY 2021). Lower rates indicate better performance.
[3] Annual Dental Visit (Ages 2 – 20 years) was added as a P4P measure in 2022 (MY 2021).
[4] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.
[5] Child and Adolescent Well-Care Visits (Ages 3—21 years) was added as a P4P measure in 2022 (MY 2021).

For the Behavioral Health program, there was another programmatic change in 2018 in the requirements for doing root cause analyses and corresponding action plans. The HEDIS FUH 7-day and 30-day measures for the 6-64 years age group were replaced with the HEDIS Overall (Ages 6+) measures for 7-day and 30-day follow-up. To incentivize improvements in its PA PMs, OMHSAS launched in 2020 a P4P program for HEDIS FUH All Ages and for REA that determined payments based on performance with respect to certain benchmarks and improvement over prior year. These changes reflect the Commonwealth's increased focus on the aging population. A root cause analysis (RCA) and "quality improvement plan" (QIP) was required for any indicator rate that fell below the NCQA Quality Compass 75th percentile for each indicator. As discussed above, all five BH-MCOs produced HEDIS FUH 7- and 30-day rates in MY 2021 that fell below the HEDIS Quality Compass 75th percentile. As a result, all five BH-MCOs submitted RCAs and QIPs for MY 2023. This RCA and QIP planning continued a proactive approach that based performance goals for MY 2023 on validated MY 2021 results.

Assessment of Quality, Timeliness, and Access

Responsibility for quality, timeliness, and access to health care services and supports is distributed among providers, payers, and oversight entities. Assessment of the healthcare quality, timeliness, and access of a HealthChoices BH-MCO, PH-MCO, and CHIP-MCO and its network must therefore include within its scope the coordination among these entities around their shared members.

PH-MCOs

Table 15 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2022 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures and CAHPS Survey, and Compliance with Medicaid and CHIP Managed Care Regulations.

Table 15: PH-MCO 2022 EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Aetna Better Health (ABH)		
Performance Improvement Projects (PIPs)		
Due to ABH's contract termination in MY 2022, recommendations were not made for the plan's identified opportunities for improvement going into 2023.		
Performance Measures and CAHPS Survey		
Due to ABH's contract termination in MY 2022, recommendations were not made for the plan's identified opportunities for improvement going into 2023.		
Compliance with Medicaid and CHIP Managed Care Regulations		
Due to ABH's contract termination in MY 2022, recommendations were not made for the plan's identified opportunities for improvement going into 2023.		
AmeriHealth Caritas Pennsylvania (ACP)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	In Project Topic in the section on racial disparities in accidental drug overdoses and pregnancy-associated deaths, it was recommended that the MCO clarify that the rates of accidental overdoses in women of childbearing age are women that are not pregnant (as compared to the drug-related, pregnancy associated deaths during the same time period).	Quality
	The MCO included an intervention for home visits for pregnant African American women with OUD and an intervention for telephonic outreach for members seen in the Emergency Department with a diagnosis of overdose. It was noted that it remains unclear how these interventions overlap to meet the stated objective and was recommended that the MCO clarify this in their report.	Quality

Measure/Project	IPRO's Recommendation	Standards
	It was recommended that the MCO update the Rationale section for the multiple target rates that were adjusted based on meeting or exceeding goals in the interim period.	Quality
	As interventions continue to be delayed, there is no evidence of completion of analysis to inform timely modifications of interventions. It was recommended that the MCO include detail in their report regarding any analysis of delayed implementation and barriers.	Quality
	It was recommended that the MCO address any threats to internal/external validity and study limitations. Due to difficulties collecting ACP data in December 2021, it was recommended that the plan elaborate on the specifics of the difficulties.	Quality
	It was recommended that the plan include discussion of limitations and expansion of future strategies as this is a population highlighted as high risk.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the MCO clarify how the diabetes pathway will increase adherence to antipsychotic medications for individuals with Schizophrenia.	Quality
	For Indicator 4b, the lack of barrier analysis and interventions was noted as of concern. It was recommended that an analysis be included for this Indicator.	Quality
	Some of the baseline and interim numbers reported in 2022 appear to differ from prior year reporting. The MCO was encouraged to include a discussion of whether ACN and ACP data were merged in 2022's report.	Quality
	Interventions not yet started do not have data to analyze for sharing of successes or opportunities for improvement. It was recommended that the MCO address this in their resubmission.	Quality
	Upon review, the connection between behavioral health and the diabetes care pathway (intervention 5/barrier 4) remained unclear. It was recommended that the MCO include more detail to explain this connection.	Quality
	Regarding delayed interventions for this project, the MCO was asked to provide more information to explain the delay.	Quality
	The Discussion/Limitations section noted some future changes to interventions. The MCO should provide more detail on this analysis and future tracking.	Quality
	The limitations detailed were identified as barriers to interventions. The MCO was recommended to expand on the plans to bolster ADT messaging and bolster African American outreach, strengthening barrier analysis and implementation of new interventions	Quality
Performance Measures and CAHPS Survey		
Emergency Room Follow Up	It is recommended that ACP improve Follow Up Care for Members with Mental Illness, Alcohol, or Other Drug Abuse or Dependence After Emergency Room Visits. Thirty day follow ups for members ages 18 to 64 years old have been an opportunity in both 2022 and 2021.	Access
Sealant Receipt for Members	It is recommended that ACP improve Receipt of Sealants on Permanent First Molars. This measure, Sealant Receipt on Permanent First Molars, has been an opportunity for improvement in both 2022 and 2021.	Access
Prenatal Smoking Screening	It is recommended that ACP improve Prenatal Smoking Screening for its pregnant members. The measures Prenatal Screening for Smoking, Prenatal Screening for Smoking during one of the first two visits, and Prenatal Screening for Environmental Tobacco Smoke Exposure were opportunities in 2021 and have been identified as opportunities again in 2022.	Access

Measure/Project	IPRO's Recommendation	Standards
Appropriate Respiratory Illness Testing	It is recommended that ACP improve Appropriate Testing for Members with Pharyngitis, especially in the 3 to 17 year-old age range. This was also identified as an opportunity for improvement in 2021.	Access, Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
Enrollment and Disenrollment	It is recommended that ACP work to address their non-compliance for the Enrollment and Disenrollment category under the MCO, PIHP, and PAHP Standards Regulations heading.	Access, Quality
Geisinger Health Plan (GEI)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It was again recommended that the MCO review guidance previously provided during the Proposal and Interim periods regarding the MCO baseline rates and discussion around why this project topic is an area of opportunity for GEI, including examining plan-specific data and rates for opportunities for improvement and ways to address disparities.	Quality
	Previously, it was recommended that the amount of improvement sought for this project, along with the interventions that will be used to achieve this improvement, be stated clearly in the report. The plan was strongly encouraged to carefully review the previous recommendations given and to use the PIP template as a direct guide for the appropriate development of this PIP.	Quality
	It was previously recommended that GEI utilize formal root cause analyses such as the 5 Whys and other modalities to determine underlying causes of their barriers. Related to this, it was recommended that the plan obtain direct member or provider feedback to identify barriers.	Quality
	It was again recommended that the MCO implement the specific guidance provided regarding their selected ITMs, including adding definitions for all and ensuring there is an ITM for each intervention that was developed.	Quality
	It was again recommended that GEI complete the Discussion section, currently for the second Interim Report. This is in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.	Quality
	It was recommended that the plan update descriptions of changes to the project within the applicable sections of the PIP document as noted in the findings.	Quality
	It was again recommended that the MCO review guidance previously provided during the Proposal and Interim periods regarding the MCO baseline rates and discussion around why this project topic is an area of opportunity for GEI, including examining plan-specific data and rates for opportunities for improvement and ways to address disparities.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was again strongly recommended that GEI use the guidance provided during Proposal and Interim reviews in conjunction with the example AIMs statement provided within the PIP template to revise the AIMs and Objectives section as indicated.	Quality
	The plan was strongly encouraged to carefully review the previous recommendations given and to use the PIP template as a direct guide for the appropriate development of this PIP. Related to this, it was recommended that the plan address the recommendations for Indicator 4, including delineation of Initiation and Engagement measures within table 3.	Quality

Measure/Project	IPRO's Recommendation	Standards
	It was again recommended that the project timeline be updated to reflect specific start dates for better tracking throughout the lifetime of the PIP.	Quality
	It was previously recommended that the MCO consider determining if medication adherence is a true barrier in this population and designating ITM 3c as a separate and independent intervention. This was not addressed and remains a recommendation.	Quality
	It was again recommended that GEI complete the Discussion section, currently for the second Interim Report. This is in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.	Quality
	It was recommended that the plan fully populate Implementation Period and Interim Submission dates within the applicable sections of the PIP document as noted in the findings.	Quality
Performance Measures and CAHPS Survey		
Annual Dental Visits	It is recommended that GEI improve dental care for members. Annual Dental Visit and Annual Dental Visits for Members with Developmental Disabilities were both opportunities in 2022 and 2021.	Access
Women's Health Screenings	It is recommended that GEI improve services for its female members. Chlamydia Screening in Women and Contraceptive Care for Postpartum Women: LARC have been opportunities for improvement in both 2022 and 2021 across all age cohorts.	Access
Appropriate Respiratory Illness Treatment	It is recommended that GEI improve appropriate treatment for respiratory illness its members. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis for members 3 months to 17 years old was an opportunity in 2021 and again in 2022	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Highmark Wholecare (HWC)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It was recommended that barriers be identified on the barrier table regarding susceptible subpopulations or interventions to reach susceptible subpopulations.	Quality
	It was recommended that the MCO's barrier analysis also include analysis of stagnating, declining, or "0" ITMs or performance indicators, as detailed in the findings.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the plan include additional information regarding how the barriers were identified, as noted above.	Quality
	It was recommended that the plan consider if plan staff could perform screening of members for food insecurity instead of hospital staff, as discussed in the review findings.	Quality
	It was recommended that the plan correct the numbering for ITMs as indicated in the findings.	Quality
Performance Measures and CAHPS Survey		
Prenatal Screenings	It is recommended that HWC improve prenatal smoking and depression screenings for its pregnant members. The following measures were opportunities for improvement in 2021, and was identified again in 2022: • Prenatal Screening for Smoking;	Quality

Measure/Project	IPRO's Recommendation	Standards
	• Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator); • Prenatal Screening for Environmental Tobacco Smoke Exposure; • Prenatal Screening for Depression; and • Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator).	
Heart Failure Admissions	It is recommended that the MCO improve heart failure admissions, particularly for members 65 years and older. Heart Failure Admission Rate increased in 2022 and has been an opportunity for improvement in 2021 and in 2022.	Quality, Access
Compliance with Medicaid and CHIP Managed Care Regulations		
Health Information Systems	Given that the MCO was found to be partially compliant in the Health Information Systems category, IPRO recommends that particular focus is placed on improving infrastructure and accessibility related to this area going forward.	Quality
Health Partners Plan (HPP)		
Performance Improvement Projects (PIPs)		
As the MCO met all review elements indicated in Table 1.2 below in the initial review, no recommendations were included related to these elements for the MCO to make for its second interim submission of this PIP. However, reviewers made one general recommendation: It was recommended that the plan update signatures/dates within the PIP document to reflect the current submission.		N/A
Performance Measures and CAHPS Survey		
Adult Access to Ambulatory Care	It is recommended that HPP improve access to preventive ambulatory care in their population. Adults' Access to Preventive/Ambulatory Health Services was an opportunity in 2021 and again in 2022 for both age cohorts. These rates also decreased in 2022.	Access
Developmental Screening & Well-Care Visits	It is recommended that HPP improve well-care visits for members 15 to 30 months old. The measure Well-Child Visits in the First 30 Months of Life (15-30 months ≥ 2 Visits) and Developmental Screening in the First Three Years of Life (all age cohorts) were opportunities in 2021 and again in 2022.	Quality
Appropriate Treatment for Respiratory Illness	It is recommended that HPP improve appropriate treatment of upper respiratory illness in its population. The measure Appropriate Testing for Pharyngitis was an opportunity in 2021 and again in 2022 for ages 18 to 64 years old.	Access
Metabolic Monitoring for Members on Antipsychotics	It is recommended that HPP improve metabolic monitoring in its members on antipsychotics. The measure Metabolic Monitoring for Children and Adolescents on Antipsychotics was an opportunity in 2021 and again in 2022 for Blood Glucose and Cholesterol Testing.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Keystone First (KF)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	In Project Topic, within the section on racial disparities in accidental drug overdoses and pregnancy-associated deaths, it was recommended that the MCO clarify that the rates of accidental overdoses in women of childbearing age are women that are not pregnant (as compared to the drug-related, pregnancy associated deaths during the same time period).	Quality

Measure/Project	IPRO's Recommendation	Standards
	Regarding the Indicator 7 objective, it was noted that it remains unclear how the two interventions that were added as indicated above overlap to meet the stated objective and was recommended that the MCO clarify this in their report.	Quality
	It was recommended that the MCO update the Rationale section for the multiple target rates that were adjusted based on meeting or exceeding goals in the interim period.	Quality
	As interventions continue to be delayed, there is no evidence of completion of analysis to inform timely modifications of interventions. It was recommended that the MCO include detail in their report regarding any analysis of delayed implementation and barriers.	Quality, Timeliness
	It was recommended that the MCO address any threats to internal/external validity and study limitations.	Quality
	It was recommended that the plan include discussion of barriers to enrollment of African American pregnant women and expansion of future strategies as this is a population highlighted as high risk.	Quality
	It was recommended that the plan update all indicator descriptions, tables and footnotes/citations as applicable and indicated in the findings.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the MCO clarify how the diabetes pathway will increase adherence to antipsychotic medications for individuals with Schizophrenia.	Quality
	It was recommended that the plan address previously identified issues with ITMs 5a and 5b, and with Indicator 4b. For Indicator 4b, the lack of barrier analysis and interventions was noted as of particular concern. It was recommended that an analysis in included for this Indicator.	Quality
	It was recommended that there be an analysis of barriers leading to a low number of members successfully completing the Transitions of Care (TOC) pathway with a Case Manager. ITM 3a denominator is seemingly low with a high rate of no 30-day readmissions in the population subset that is reached. This appears to be an impactful intervention that has the potential to benefit more members if the barriers to reaching more members are better understood.	Quality
	Interventions not yet started do not have data to analyze for sharing of successes or opportunities for improvement. It was recommended that the MCO address this in their resubmission.	Quality
	Upon review, the connection between behavioral health and the diabetes care pathway (intervention 5/barrier 4) remained unclear. It was recommended that the MCO include more detail to explain this connection.	Quality
	Regarding delayed interventions for this project, the MCO was asked to provide more information to explain the delay.	Quality
	The Discussion/Limitations section noted some future changes to interventions. The MCO should provide more detail on this analysis and future tracking.	Quality
	It was recommended that the plan update all tables and footnotes/citations as applicable and indicated in the findings	Quality
Performance Measures and CAHPS Survey		
Follow Up Care for ADHD	It is recommended that KF improve Follow Up Care for Children Prescribed ADHD Medication. This measure was an opportunity in 2021 and again in 2022 for initiation phase.	Quality

Measure/Project	IPRO's Recommendation	Standards
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
United Healthcare (UHC)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It was recommended that the MCO provide an assessment of barriers to Indicator 6b, particularly given the decrease of more than 20 percentage points.	Quality
	It was recommended that the plan double check data and update all tables and footnotes/citations as applicable and indicated in the findings	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the plan provide more information regarding the discussions of the impact of COVID for ITMs 3 and 4.	Quality
	It was recommended that the plan provide more information on the updated end date for Intervention 6.	Quality
	It was recommended that the plan update all tables and footnotes/citations as applicable and indicated in the findings	Quality
Performance Measures and CAHPS Survey		
Women's Health	It is recommended the MCO improve access to services related to women's health. The following measures were opportunities for improvement in 2021 and again in 2022: o Breast Cancer Screening; and o Cervical Cancer Screening.	Access
Services for Members on Antipsychotic Medication	It is recommended the MCO improve access to services for its members on antipsychotic medications. Adherence to Antipsychotic Medications for Individuals with Schizophrenia was an opportunity for improvement in 2021 and again in 2022.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
UPMC for You (UPMC)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It was recommended that the MCO assess if there is a common theme reported by members with regard to barriers to MAT adherence for which the plan can focus additional efforts.	Quality
	The plan reports continual assessment identifying disparities, although no additional interventions have been added to address identified disparities. It was recommended that the plan focus more on the region identified above and develop targeted interventions to address this susceptible subpopulation.	Quality
	It was recommended that the plan conduct barrier analysis for declining indicators and ITMs, specifically Indicator 6 and ITM 6. Reviewers noted that interventions typically require ongoing evaluation, and most studies are impacted by threats to validity.	Quality

Measure/Project	IPRO's Recommendation	Standards
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the barrier table should include information on barriers that was obtained from members to inform interventions. Susceptible subpopulations should also be included as a barrier, with targeted interventions.	Quality
	It was recommended that the plan review the definitions of external and internal validity and use the examples provided in the template. Reviewers noted that interventions typically require ongoing evaluation, and most studies are impacted by threats to validity.	Quality
	It was recommended that declining or stagnating ITMs be listed on the barrier table to inform modified interventions and ITMs.	Quality
Performance Measures and CAHPS Survey		
Women's Health Screenings	It is recommended that UPMC improve screening access for women's health issues. Chlamydia Screening in Women (15-20 years old, 21-24 years old, and total) was an opportunity in 2021 and again 2022.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

CHIP-MCOs

Table 16 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2022 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures and CAHPS Survey, and Compliance with Medicaid and CHIP Managed Care Regulations.

Table 16: CHIP-MCO 2022 EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Aetna Better Health (ABH)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	Regarding the project topic, it was recommended that the MCO provide separate aim and objective statements, using the guidance indicated by the reviewers in the findings.	Quality
	It was recommended that the MCO finalize the data and text for Indicator 2, to include a HEDIS Target Percentile as noted and remove internal plan notes and to add final rates for Indicator 3 when they are available.	Quality
	For interventions, it was recommended that the MCO provide additional information for Interventions 1-3 as indicated in the findings.	Quality
	It was recommended that the plan update the intervention tracking measures (ITM) descriptions and numbering as indicated in the findings (e.g., the first ITM listed as 2b should be 2a and the numerators and denominators for (ITMs) 3a and 3b should be rewritten to follow format of other items (specify "number of XX" who meet "XX" criteria))	Quality
Improving Blood Lead Screening Rate in Children	Given that Indicator #4 is not discussed in Aims or Objectives, it was recommended that the MCO include the information requested in the template for this indicator for all applicable sections.	Quality

Measure/Project	IPRO's Recommendation	Standards
	It was recommended that ABH reexamine Indicators 3 and 4 which, as defined, are more appropriately represented as ITMs. Related to these indicators, it is unclear what goals are being measured for them, what barriers are being addressed, and what the means are to improve these goals. ABH is advised to review all findings for these indicators throughout the review and make relevant updates.	Quality
	Please define all acronyms used (e.g., "ELI, CMO, MM and QM staff, "QNXT system.").	Quality
	For data collection and analysis, it was recommended that ABH clarify the methods of how data will be analyzed, what will be used to monitor and analyze case management (CM) outreach results, and any new barriers that might be identified.	Quality
	It was recommended that ABH ensure there is a clear difference between the barriers. Specifically for barriers 3 and 4, ABH was provided a suggestion by the reviewers for consideration.	Quality
	It was recommended that ABH clarify the timing for the barriers and interventions as detailed in the findings.	Quality
Performance Measures and CAHPS Survey		
Contraceptive Care	It is recommended that ABH focus efforts on improving access to contraceptive care for their members. Contraceptive Care for All Women (15–20 years): Most or Moderately Effective was identified as an opportunity for improvement in 2021 and in 2022.	Access
Follow Up Care After Hospitalization	It is recommended that ABH focus efforts on follow up care for members who were hospitalized for mental illness. Thirty day follow ups were identified as an opportunity for improvement in 2021 and 2022 for the Follow Up After Hospitalization For Mental Illness measure.	Access
Dental Care	It is recommended that ABH focus efforts on improving dental care for its members, particularly sealant receipt for members with their permanent first molars. Both indicators for the measure Sealant Receipt on Permanent First Molars were opportunities for improvement in 2022.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Capital Blue Cross (CBC)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that CBC develop the following sections: • Describe how PIP Topic addresses your member needs and why it is important to your members. • Describe high-volume or high-risk conditions addressed.	Quality
	It is recommended that CBC add an Aim Statement that addresses what will be improved, by how much, among whom, and over what timeframe. The MCO should ensure the Aim statement(s) includes each Performance Indicator.	Quality
	At the end of the section Data Collection and Analysis Procedures, it is recommended that CBC provide more detail regarding individual ITM data collection and monitoring (e.g., how are "touchpoints available" and "touchpoints delivered" recorded and collected).	Quality
	It is recommended that CBC list the data sources that informed "Lack of parental awareness" and "Lack of provider awareness" barriers.	Quality

Measure/Project	IPRO's Recommendation	Standards
	It was recommended that CBC include target rates in the report.	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that CBC develop the following sections: • Describe how PIP Topic addresses your member needs and why it is important to your members. Describe high-volume or high-risk conditions addressed.	Quality
	It is recommended that CBC add an Aim Statement that addresses what will be improved, by how much, among whom, and over what timeframe. The MCO should ensure the Aim statement(s) includes each Performance Indicator.	Quality
	At the end of the section Data Collection and Analysis Procedures, it is recommended that CBC provide more detail regarding individual ITM data collection and monitoring (e.g., how are "touchpoints available" and "touchpoints delivered" recorded and collected).	Quality
	It is recommended that CBC list the data sources that informed "Lack of parental awareness" and "Lack of provider awareness" barriers.	Quality
	It was recommended that CBC include target rates in the report.	Quality
Performance Measures and CAHPS Survey		
Developmental Screening	It is recommended that CBC focus efforts on improving developmental screenings for their child population three years old and younger. Ages 2 years, 3 years, and Total for Developmental Screening in the First Three Years of Life measure were opportunities for improvement in 2022 as well as in 2021.	Access
Ambulatory Care: Outpatient Visits	It is recommended that the MCO improve outpatient visit utilization for ambulatory care. This measure was an opportunity in 2021 and has been identified as opportunities again in 2022 for all age cohorts.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Geisinger Health Plan (GEI)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that GEI include the performance indicators and population of interest in AIM statement.	Quality
	It is recommended that GEI provide more detailed description for their first performance indicator. The numerator is visits, while denominator is members.	Quality
	Only 1 barrier identified and not specified among whom "telephonic outreach" was conducted. No MCO-focused barriers identified or addressed. It is recommended that GEI conduct a more comprehensive barrier analysis that identifies MCO-level barriers and/or provider-focused barriers.	Quality
	Intervention 1 is passive and unlikely to be effective in moving performance indicators (PIs). IPRO suggests replacing with more active intervention(s). It is recommended that GEI add interventions to address additional MCO and/or provider-focused barriers.	Quality
	It is recommended that GEI revise numerator for ITM 2a. Numerator must be a subset of denominator. As written, this is not the case.	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that GEI complete PIP implementation period and indicate health plan.	Quality
	It is recommended that GEI include the performance indicators and population of interest in AIM statement.	Quality

Measure/Project	IPRO's Recommendation	Standards
	It is recommended that GEI specify timeframe for performance indicators. Claims data is indicated as the only data source for all three indicators. This is not consistent with numerator definitions for indicators 1 and 3 and is not appropriate data source for numerator of indicator 2.	Quality
	It is recommended that GEI modify eligible population for indicators 2 and 3 to reflect that these are only members enrolled in CHIP.	Quality
	It is generally discouraged for MCOs to use claims data for barrier analysis, as claims data doesn't provide insight into why a process isn't occurring. The fact that members are being screened but not tested is not a barrier. A barrier is something that speaks to why this is the case. It is recommended that GEI conduct a barrier analysis that involves collecting information from plan-staff, members and/or providers.	Quality
	A monthly newsletter is passive and unlikely to be effective in moving performance indicators. It is recommended that GEI replace this with more active intervention(s). Please provide more detail related to how and by whom education will be delivered to providers. These interventions should be separated out as should their associated items.	Quality
	It is recommended that GEI separate out interventions and develop separate items for each.	Quality
Performance Measures and CAHPS Survey		
Developmental Screening	It is recommended that the MCO improve access to developmental screenings for their members. Developmental Screening in the First Three Years of Life (all age cohorts) was an opportunity in 2021 and has been identified as an opportunity again in 2022.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Highmark HMO (HMO)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that Highmark expand the AIM statement so that it provides answers to the following questions "How much improvement, to what, for whom, and by when?" Please be sure that information provided in aim statement aligns with what is stated in the objective statement(s).	Quality
	It is recommended that Highmark add data from MY 2021 for numerator, denominator, and rates. If not available, please state this. Table 2 should include the data; the descriptions for numerator and denominator are for Table 3. For Target for Indicator 2, please specify an actual rate you are targeting and provide a justification.	Quality
	It is recommended that Highmark clarify definition of age groups, example: age 19 as of Dec. 31, 2021 or reference "eligible population."	Quality
	It is recommended that Highmark consider removing the job requirements for the data collectors and providing concise description of how you are QA'ing data, who does it, and how often. If doing incidence rate ratio (IRR), what are the thresholds and mitigating procedures when issues are identified?	Quality

Measure/Project	IPRO's Recommendation	Standards
	It is recommended that Highmark describe who is going to monitor ITMs to assess progress and how progress will be evaluated from an analytic standpoint.	Quality
	It is recommended that Highmark provide clarification regarding what "outreach activities" will be undertaken. What will be the mode of outreach? Frequency? Who is conducting outreach?	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that Highmark delete all unused areas of Table 5 (i.e., remove #2, #3, #4 #6 and Barrier 4) and re-number ITMs sequentially regardless of the barrier they are under.	Quality
Performance Measures and CAHPS Survey		
Child's Overall Mental or Emotional Health	It is recommended that the MCO work to provide resources for its members struggling with mental health. The percentage of respondents who rated their child's mental or emotional health as "excellent" or "very good" has fallen each year since MY 2019. The MY 2021 rate is also below the MY 2021 weighted average.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Health Partners Plan (HPP)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that HPP provide more detail about processes for ensuring valid and reliable data. What kinds of QA processes are in place? Who carries them out? Who oversees them? How often does this happen? If IRR is conducted, what is the threshold for acceptable performance and, if not met, what are the mitigating procedures in place?	Quality
	It is recommended that HPP provide more information about dental provider care gap outreach/member care gap program for intervention 2.	Quality
	It is recommended that HPP provide more information about how care management will support members in obtaining preventive dental visits for intervention 4.	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that HPP include more information in the Aim statement regarding the members impacted (see example in the template).	Quality
	It is recommended that HPP elaborate more fully on how data for Indicator #2 will be tabulated, including who will be responsible for the data collection.	Quality
	It is recommended that HPP define Validity and Reliability for Indicators #2 & #3.	Quality
	It is recommended that HPP define and/or identify members of "focus group" responsible for identifying barrier #1.	Quality
	It is recommended that HPP indicate the "actual start dates" for their interventions and ITMs.	Timeliness
Performance Measures and CAHPS Survey		
Well Care Visits	It is recommended that the MCO improve access to well-care visits. Child and Adolescent Well-Care Visits was an opportunity in 2021 and has been identified as an opportunity again in 2022.	Quality, Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

Measure/Project	IPRO's Recommendation	Standards
Independence Blue Cross (IBC)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that IBC add an appropriate aim statement. The aim statement should answer the questions: what do we want to improve, among whom, by how much, and over what time frame. All information provided in the aim statement should be consistent with information in the objectives.	Quality
	It is recommended that IBC reframe exclusion criteria for indicators 1-4, as they are not clear.	Quality
	For interventions 1, 3, and 4, please provide more detail about how these notifications will be sent. Mailings are passive interventions which are generally not effective. It is recommended that MCOs include at least one active intervention.	Quality
	It is recommended that IBC confirm if any interventions have started and include their actual start dates. If interventions have not begun, please explain why and the plan to begin interventions as soon as possible.	Quality
	It is recommended that IBC modify ITM to be intervention-specific. For example, for intervention 1/ITM 1a, you could look at the proportion of members with no dental claims pre intervention who were outreached or of those outreached who had no prior claims, how many had a visit in the time-frame post-intervention.	Quality
Improving Blood Lead Screening Rate in Children	Indicator #3 is not clearly defined as to what effect this Indicator will have on the PIP study. The indicator should speak to how increasing the number of well-child visits relates to blood lead level collection. Also, there should be ITMs and barriers associated with this Indicator. An aim statement should be specific, measurable and should answer the questions, how much improvement, to what, for whom, and by when?	Quality
	It is recommended that IBC add staff qualifications to data collection section. For medical records abstraction, please describe the training, IRR testing and quality monitoring.	Quality
	It is recommended that IBC explain the data analysis procedures and, if statistical testing is conducted, specify the procedure used. Describe the methods used to analyze data, whether measurements were compared to prior results or similar studies, and if results were compared among regions, provider sites or other subsets or benchmarks.	Quality
	It is recommended that IBC reassess and clarify its barriers identified for this PIP.	Quality
Performance Measures and CAHPS Survey		
Contraceptive Care	It is recommended that the MCO improve access to contraceptive care for its members. Contraceptive Care for All Women (15–20 years): Most or Moderately Effective was an opportunity in 2022 for all age cohorts.	Access
Lead Screening	It is recommended that the MCO improve lead screening their population. Lead Screening in Children (2 years) was an opportunity in 2021 and has been identified as an opportunity again in 2022.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
First Priority Health (NEPA)		
Performance Improvement Projects (PIPs)		

Measure/Project	IPRO's Recommendation	Standards
Improving Access to Pediatric Preventive Dental Care	It is recommended that Highmark expand the AIM statement so that it provides answers to the following questions "How much improvement, to what, for whom, and by when?" Please be sure that information provided in aim statement aligns with what is stated in the objective statement(s).	Quality
	It is recommended that Highmark add data from MY 2021 for numerator, denominator, and rates. If not available, please state this. Table 2 should include the data; the descriptions for numerator and denominator are for Table 3. For Target for Indicator 2, please specify an actual rate you are targeting and provide a justification.	Quality
	It is recommended that Highmark clarify definition of age groups, example: age 19 as of Dec. 31, 2021 or reference "eligible population."	Quality
	It is recommended that Highmark consider removing the job requirements for the data collectors and providing concise description of how you are QA'ing data, who does it, and how often. If doing IRR, what are the thresholds and mitigating procedures when issues are identified?	Quality
	It is recommended that Highmark describe who is going to monitor ITMs to assess progress and how progress will be evaluated from an analytic standpoint.	Quality
	It is recommended that Highmark provide clarification regarding what "outreach activities" will be undertaken. What will be the mode of outreach? Frequency? Who is conducting outreach?	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that Highmark delete all unused areas of Table 5 (i.e., remove #2, #3, #4 #6 and Barrier 4) and re-number ITMs sequentially regardless of the barrier they are under.	Quality
Performance Measures and CAHPS Survey		
Developmental Screening	It is recommended that the MCO improve well-care visits for members. The measure Developmental Screening in the First Three Years of Life (all age cohorts) were opportunities in 2021 and again in 2022.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Highmark PPO (PPO)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that Highmark expand the AIM statement so that it provides answers to the following questions "How much improvement, to what, for whom, and by when?" Please be sure that information provided in aim statement aligns with what is stated in the objective statement(s).	Quality
	It is recommended that Highmark add data from MY 2021 for numerator, denominator, and rates. If not available, please state this. Table 2 should include the data; the descriptions for numerator and denominator are for Table 3. For Target for Indicator 2, please specify an actual rate you are targeting and provide a justification.	Quality
	It is recommended that Highmark clarify definition of age groups, example: age 19 as of Dec. 31, 2021 or reference "eligible population."	Quality

Measure/Project	IPRO's Recommendation	Standards
	It is recommended that Highmark consider removing the job requirements for the data collectors and providing concise description of how you are QA'ing data, who does it, and how often. If doing IRR, what are the thresholds and mitigating procedures when issues are identified?	Quality
	It is recommended that Highmark describe who is going to monitor ITMs to assess progress and how progress will be evaluated from an analytic standpoint.	Quality
	It is recommended that Highmark provide clarification regarding what "outreach activities" will be undertaken. What will be the mode of outreach? Frequency? Who is conducting outreach?	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that Highmark delete all unused areas of Table 5 (i.e., remove #2, #3, #4 #6 and Barrier 4) and re-number ITMs sequentially regardless of the barrier they are under.	Quality
Performance Measures and CAHPS Survey		
Women's Health Screenings	It is recommended that the MCO improve screening access for its members. Chlamydia Screening in Women was an opportunity in 2021 and in 2022 was again identified as an opportunity.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
United Healthcare Community Plan (UHC)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that UHC add an Aim Statement. The Aim Statement must address what will be improved, among whom, by how much, and over what timeframe. Please ensure the Aim statement(s) includes all Performance Indicators.	Quality
	Interventions 2 and 3 have TBD as the start date. It is recommended that UHC clarify whether these interventions addressed the identified barriers or should they be removed or modified.	Quality
	ITMs have been confused with Performance Indicators. It is recommended that UHC updated their ITMs so that they monitor the implementation of the Intervention, rather than the children who received annual dental visits or sealants.	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that UHC clarify this sentence in paragraph 1: "According to the CDC environmental health tracking tool Pennsylvania ranks fifth in the country and first in PA for old housing, with 88.77% of housing built prior to 1980." It seems to be missing some punctuation, or maybe "Pennsylvania" is intended to refer to a city or county in PA?	Quality
	It is recommended that UHC clarify the difference in outreach between Quality Team Member Outreach (ITM #2) and Quest [P]ilot Program outreach (ITM #3). Are they 2 different programs, or is Quest an outside vendor? For ITM #7, how are members approached/identified for the home testing kit--through outreach or their physician?	Quality
Performance Measures and CAHPS Survey		
Access to Screenings	It is recommended that the MCO improve access to screenings for its members. Chlamydia Screening in Women (16–20 years) and Developmental Screening in the First Three Years of Life— Total were opportunities in 2022.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		

Measure/Project	IPRO's Recommendation	Standards
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
UPMC for Kids (UPMC)		
Performance Improvement Projects (PIPs)		
Improving Access to Pediatric Preventive Dental Care	It is recommended that UPMC provide an aim statement in addition to the objectives. The aim statement should answer the questions: what you want to improve, among whom, by how much, and over what timeframe. All information provided in the aim statement should be consistent with what is provided in the objective statements.	Quality
	It is recommended that UPMC provide more detail regarding how the education will be provided for Intervention 1.	Quality
Improving Blood Lead Screening Rate in Children	It is recommended that UPMC better define the rationale for target rates for Indicators #2 & #3. Are there state or national benchmarks you are basing these numbers on?	Quality
	It is recommended that UPMC define PL SQL tools and SQL queries in their Data Collection section.	Quality
	It is recommended that UPMC include actual start date for all interventions.	Quality
Performance Measures and CAHPS Survey		
Access to Screenings	It is recommended that the MCO improve access to screenings for its members. Lead Screening in Children (2 years) and Developmental Screening in the First Three Years of Life (all cohorts) was an opportunity in 2022.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

BH-MCOs

Table 17 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2022 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures, and Compliance with Medicaid Managed Care Regulations their relevance to the Quality, Timeliness, and Access domains.

Table 17: BH-MCO 2022 EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Beacon Health Options of Pennsylvania (BHO)		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	IPRO advised that any and all PIP intervention activities would need to be monitored using ITMs. In addition, the population health strategy intervention was discontinued entirely, effective 2022. IPRO advised that BHO would need to find a suitable population health strategy going forward to satisfy this required component of the PIP.	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with BHO's findings of its RCA and proposed remediations in its QIP, which center on addressing: COVID-19 fatigue through provider engagement and Value Based Purchasing (VBP) interventions, increasing timely outreach post-discharge, while addressing social determinants of health, and improving communication and coordination among providers and related resources.	Timeliness, Access
PA-specific Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with BHO's findings of its RCA and proposed remediations in its QIP, which center on addressing: COVID-19 fatigue through provider engagement and VBP interventions, increasing timely outreach post-discharge, while addressing social determinants of health, and improving communication and coordination among providers and related resources.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	BHO should continue to conduct RCA into the drivers of readmissions among members discharged from an inpatient psychiatric stay. It should leverage the barrier analyses already conducted for its PEDTAR PIP, but also conduct additional RCA for members without AOD diagnoses.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Assurances of adequate capacity and services	BHO was partially compliant with a substandard that 100% of members are given the choice of two providers at each level of care within 30/60 miles urban/rural met. The Primary Contractors with BHO were not fully compliant for all applicable levels of care. BHO should work with these contractors to expand its network, if needed, to come into compliance at all applicable levels of care.	Quality, Timeliness, Access
Availability of Services	In addition to the above-mentioned partial compliance on provider choice, BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Coordination and continuity of care	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access

Measure/Project	IPRO's Recommendation	Standards
Coverage and authorization of services	In addition to the partial compliance centered on defining a program of care, BHO was found partially compliant on the substandard that denial notices be issued to members according to required timeframes and use the required template language. IPRO notes here the Corrective Action Plan (CAP) Required, namely: BHO must ensure that when requested services are denied, approved services are clearly stated to members in the denial letter. This can be accomplished by using the appropriate OMHSAS-approved templates.	Quality, Timeliness, Access
Practice Guidelines	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Quality assessment and performance improvement program	BHO was found partially compliant with substandards concerned with the QM Program Description and Work Plan. IPRO concurs with OMHSAS' recommendations and corrective action plan: The Program Description states that Quality Improvement Activities / Projects will be identified for improvement in clinical care and services areas, but specific Performance Improvement Projects are not identified. The Work Plan lists data to be collected under each activity and mentions members with special health needs. It is recommended that this information be stated and more clearly described in the Program Description. For the OMHSAS CAP, BHO needs to clarify goals and activities in the 2022 Work Plan to identify specific and measurable goals.	Quality, Timeliness, Access
Grievance and appeal systems	BHO was found partially compliant on the substandard that denial notices be issued to members according to required timeframes and use the required template language. IPRO notes here the Corrective Action Plan Required, namely: BHO must ensure that when requested services are denied, approved services are clearly stated to members in the denial letter. This can be accomplished by using the appropriate OMHSAS-approved templates. BHO was found not compliant with the substandard that Complaint case files include documentation of any referrals and subsequent corrective action and follow-up related to complaint issues. BHO should ensure that any follow-up and corrective actions are documented in a member's file or appropriately referenced for ready access.	Quality, Timeliness, Access
Community Behavioral Health (CBH)		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	CBH should consider ways to speed expedite its Plan Do Study Act (PDSA) cycles where delays in implementation were noted. Finally, as of the writing of their report, CBH had terminated its population health strategy intervention with no replacement. A population health strategy intervention is a requirement of this PIP, which will need to be met. Since the vaping education intervention was fully implemented in 2021, this is not an issue for this review, but will be a concern going forward until addressed.	Quality, Timeliness, Access
Performance Measures		

Measure/Project	IPRO's Recommendation	Standards
HEDIS Follow-Up After Hospitalization for Mental Illness rates	CBH has been working on RCAs and QIPs related to their FUH rates for a number of years now, and rates continue to fall. CBH's new PIP centering on improving the continuum of SUD care, particularly for Black, non-Hispanic members with disproportionately low treatment initiation and engagement rates, can be expected to help improve FUH rates to the extent there is comorbidity between SUD and mental illness. Still, for MCOs like CBH facing systemic resistance to policy efforts with no clear culprit, logic models of change can be operationalized using tools and techniques, including system dynamics simulation modeling, to help identify potential leverage points for bringing about change at lower cost.	Timeliness, Access
PA-specific Follow-Up After Hospitalization for Mental Illness rates	CBH has been working on RCAs and QIPs related to their FUH rates for a number of years now, and rates continue to fall. CBH's new PIP centering on improving the continuum of SUD care, particularly for Black, non-Hispanic members with disproportionately low treatment initiation and engagement rates, can be expected to help improve FUH rates to the extent there is comorbidity between SUD and mental illness. Still, for MCOs like CBH facing systemic resistance to policy efforts with no clear culprit, logic models of change can be operationalized using tools and techniques, including system dynamics simulation modeling, to help identify potential leverage points for bringing about change at lower cost.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	CBH's REA rate continues to rise. CBH should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission. A next logical step is to conduct Difference in Difference (DiD) tests to compare rates of improvement in REA between members who carry an SUD diagnosis and those who don't to assess whether PIP interventions are being effective. Similar analysis could be conducted for members with SPMI who are participating in the ICP program (and compared to those who are not) to determine whether specific BH-PH integration interventions are also impacting REA.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Availability of Services	CBH was partially compliant with the substandard that the medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. A limited sample active case management review has already identified next steps for their medical management team. Now it remains for the steps to be operationalized with timelines to begin implementation.	Quality, Timeliness, Access
Coordination and continuity of care	CBH was partially compliant with documentation of correct application of medical necessity criteria in care management (CM). IPRO concurs with the recommendations made by OMHSAS: CBH should consider training and/or oversight with feedback of the denial letters, with focus on the clinical rational specific to the individual; and CBH should consider initiating a continuous quality improvement process based on identified goals. Suggested action items include the following: Operationalize each of the "next steps" identified in the ACMR; Prioritize the next steps and establish timeline for implementation.	Quality, Access
Coverage and authorization of services	CBH was partially compliant due in part to with issues with denial letters. IPRO concurs with OMHSAS recommendations from existing correction action plans centering on the implementation of the denial letter template and related standards.	Quality, Access

Measure/Project	IPRO's Recommendation	Standards
Practice guidelines	CBH was partially compliant with the substandard that the medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. A limited sample active case management review has already identified next steps for their medical management team. Now it remains for the steps to be operationalized with timelines to begin implementation.	Quality, Timeliness, Access
Provider selection	CBH should ensure that results of provider profiling be incorporated into recredentialing.	Quality
Grievance and appeal systems	IPRO concurs with the following OMHSAS proposed remediations and CAPs: Investigators should not give their preliminary impressions on a panel decision to the member or member representative. CBH Complaint and Grievance Managers must develop a monitoring process that ensures that there is adequate and organized case documentation. CBH must conduct and document appropriate follow-up by ensuring that providers are completing corrective action plans that are assigned by CBH. If the documentation is not located in the Complaint record; CBH must note where the documentation can be found. CBH must use the appropriate Denial Letter Template as indicated in Appendix AA when notifying Members. CBH must provide members receiving Acute Inpatient Services with an effective date at least 1 day after the date of the denial notice to ensure the Member has the ability to file a complaint or grievance and continue services until a decision, if desired. OMHSAS recommends that CBH examine their processes to ensure Denial Letters reference applicable guidelines when making a decision. OMHSAS also recommends that CBH examine their processes to ensure Denial Letters do not contain language which attempts to educate, instruct, or case manage the Member or provider. OMHSAS recommends that CBH examine their processes to ensure Denial Letters do not provide instruction or direct what a person who is not a BH provider is doing.	Quality, Timeliness, Access
Community Care Behavioral Health (CCBH)		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	It was noted that overall Year 1 performance indicator goals had not been achieved, but some counties did see improvements. IPRO suggested CCBH drill deeper into the differences in these counties in order to possibly extract lessons. In addition, comparison to national % changes in relevant measures like FUI may also provide a way to check for counterfactuals.	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	In a reversal from the previous year, 2021 saw a significant drop in CCBH's follow-up rates. In its RCA, CCBH notes many factors centering mostly on its members, for example, problems addressing childcare or obtaining transportation, although CCBH also notes larger provider (e.g., lack of psychiatrists) and systemic issues such as stigma. Its RCA remains robust, as do many of its interventions. QIP interventions that show promise, like the Admissions Interview--members who received an Admission Interview were 13 percentage points more likely to have follow-up in 30-days—and High Risk Care Management, should be continued and possibly expanded. Where questions remain, CCBH should continue to leverage its in-house data to evaluate interventions like the Collaborative Care at FQHCs to determine which interventions are helping improve follow-up rates and which ones are not, and why. In its current	Timeliness, Access

Measure/Project	IPRO's Recommendation	Standards
	PEDTAR PIP, CCBH is leveraging its partnership with counties, single county authorities, and Centers of Excellence (COEs) to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. To the extent that there is comorbidity, CCBH should expect FUH of such members to improve as their SUD conditions are better identified and managed. The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention. And the expansion of VBP arrangements to COEs in CCBH's service area effective January 2023 should also be expected to improve FUH of MH-SUD comorbid members. Expansion of the network also shows promise in addressing MH treatment shortage areas. Finally, CCBH's focus on addressing health equity, as evidenced by its recent NCQA Health Equity Accreditation, should translate to reduce observed inequities in many quality areas, including follow-up.	
PA-specific Follow-Up After Hospitalization for Mental Illness rates	See recommendations for HEDIS FUH.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness, although the MCO rate remained unchanged from MY 2020, suggesting CCBH should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities (SCAs), and Centers of Excellence (COE) to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that ultimately impact quality, timeliness, and access to care, the MCO can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention. A next logical step is to conduct Difference in Difference (DiD) tests to compare rates of improvement in REA between members who carry an SUD diagnosis and those who don't to assess whether PIP interventions are being effective. Similar analysis could be conducted for members with serious persistent mental illness (SPMI) who are participating in the ICP program (and compared to those who are not) to determine whether specific BH-PH integration interventions are also impacting REA.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Availability of Services	CCBH was found partially compliant for this category based on non-compliance with the substandard requiring that Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria (MNC) and active care management that identify and address quality of care concerns. IPRO	Quality, Timeliness, Access

Measure/Project	IPRO's Recommendation	Standards
	concurs with OMHSAS' proposed corrective action: CCBH must revise its psychological testing request form to include a dedicated space for the specific referral question to be answered through psychological testing. Consistent with MNC for psychological testing, this dedicated space should encourage the requesting provider to explain how the psychological testing is expected to answer the referral question or how the referral question could not be answered on the absence of the requested testing.	
Coordination and continuity of care	CCBH was found partially compliant for this category based on non-compliance with the substandard requiring that Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. IPRO concurs with OMHSAS' proposed corrective action: CCBH must revise its psychological testing request form to include a dedicated space for the specific referral question to be answered through psychological testing. Consistent with MNC for psychological testing, this dedicated space should encourage the requesting provider to explain how the psychological testing is expected to answer the referral question or how the referral question could not be answered on the absence of the requested testing.	Quality, Timeliness, Access
Coverage and authorization of services	In addition to the non-compliance with the application of medical necessity criteria substandard, CCBH was partially compliant with a substandard specifying content and intelligibility of decision notices. IPRO concurs with the following OMHSAS recommendations and CAPs: Recommendation: CCBH should ensure that their PAs are careful in adding language like "less intensive," "less restrictive," and "severity level" to denial rationales. Medically necessary services may not be denied because another "less intensive" service is not tried. Corrective Action Plan (CAP): CCBH must ensure that denial rationales are clear and document a member's behaviors, symptoms, clinical needs and/or improvements to form the basis of a medical necessity determination without using unnecessary language that educates, instructs, or case manages.	Quality, Timeliness, Access
Practice guidelines	CCBH was found partially compliant for this category based on non-compliance with the substandard requiring that Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. IPRO concurs with OMHSAS' proposed corrective action: CCBH must revise its psychological testing request form to include a dedicated space for the specific referral question to be answered through psychological testing. Consistent with MNC for psychological testing, this dedicated space should encourage the requesting provider to explain how the psychological testing is expected to answer the referral question or how the referral question could not be answered on the absence of the requested testing.	Quality, Timeliness, Access
Grievance and appeal systems	In addition to being partially compliant with the substandard specifying content and intelligibility of decision notices, CCBH was partially complaint with the substandard requiring Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member. IPRO concurs with OMHSAS' CAP: A dated witness signature and provider plan identification number must be added to CCBH's "Authorization for Representation: Member Consent for Provider to File a Grievance" form and consistently completed to meet Appendix H requirements.	Quality, Timeliness, Access

Measure/Project	IPRO's Recommendation	Standards
Magellan Behavioral Health		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	Opportunities for improvement were limited to clarifying discussion of preliminary findings.	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	Although MBH's FUH rate fell slightly in MY 2021, the decrease was smaller than the Statewide drop. MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide-Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management."	Timeliness, Access
PA-specific Follow-Up After Hospitalization for Mental Illness rates	MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide-Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management."	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	MBH's REA rate improved (decreased) significantly from MY 2020 by 1.6 percentage points. For their PEDTAR PIP, MBH identified significant opportunities for improvement in several areas, starting with high rates of AMA and AWOL discharges from high levels of SUD inpatient care. The PIP interventions as a set seek to address the entire continuum of care, including prevention and early detection as well a complex chronic disease management of comorbid conditions. MBH's multifaceted approach in its PIP targeting both member engagement but also provider training and network enhancements places the MCO in a strong position to decrease readmission rates after hospitalization for mental illness for members who also have SUD. A next logical step is to conduct Difference in Difference (DiD) tests to compare rates of improvement in REA between members who carry an SUD diagnosis and those who don't to assess whether PIP interventions are being effective. Similar analysis could be conducted for members with SPMI who are participating in the ICP program (and compared to those who are not) to determine whether specific BH-PH integration interventions are also impacting REA.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Coverage and authorization of services	MBH was partially compliant with a substandard related to the correct use of available denial letter templates and timelines. In 2021 MBH showed an improvement in use of the correct template, but OMHSAS noted an area for improvement is ensuring the effective date is correct based upon the type of request made. IPRO concurs with OMHSAS' recommendation: MBH must ensure Denial Letters are	Timeliness, Access

Measure/Project	IPRO's Recommendation	Standards
	mailed to the Member at least ten (10) days prior to the effective date of the denial of authorization for continued services.	
Grievance and appeal systems	MBH was partially compliant with Grievance and appeal systems standard due to deficiencies associated with maintaining effective oversight of the complaint process. IPRO concurs with the findings of the corrective action plan: Decision letters need to be clear and concise by including a summary of the findings from the investigation rather than explaining the entire investigation process. IPRO concurs with the following recommendations: Magellan should develop criteria to determine when an on-site provider review is warranted (e.g., health and safety concerns). It also recommended that Magellan outline criteria to determine when follow-up is needed, and Magellan should develop a process to determine member satisfaction with the Complaint outcome and document where appropriate. MBH was also partially compliant with substandards concerned with the communication of Grievance and Fair Hearing processes, procedures and Member rights. MBH should formalize a process to follow up with members to assess satisfaction with the Grievance process. In addition, MBH should identify criteria related to onsite provider reviews and follow-up actions.	Quality, Timeliness, Access
PerformCare		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	Opportunities for improvement center primarily on reporting and discussion of findings. This includes further clarifying ITMs to more meaningfully monitor intervention activities and downstream impacts. For example, IPRO recommended PerformCare implement ITMs for two interventions with the same ITM that will distinguish their upstream activities from one another and thus enable PerformCare to identify where breakdowns or successes are occurring in the implementation of the interventions.	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	PerformCare's FUH rates continue to decrease. IPRO concurs with PerformCare's findings of its RCA and proposed remediations in its QIP, which center on addressing: expanding Re-Engineered Discharge (RED) with two additional mental health inpatient providers; "develop a joint operating agreement between facilities and mental health outpatient providers to ensure communications between the MH IP facilities, Members and MH OP providers and compliance with new value based purchasing requirements;" and development and dissemination of resources and information related to telehealth and viable alternatives for members. PerformCare also noted a lack of engagement among both providers and members related to getting aftercare. IPRO recommends PerformCare leverage interviews, focus groups, member satisfaction surveys, and similar sources to drill deeper into the causes of this lack of engagement so that it can identify concrete interventions to address it.	Timeliness, Access
PA-specific Follow-Up After Hospitalization for Mental Illness rates	PerformCare's FUH rates continue to decrease. IPRO concurs with Perform Care's findings of its RCA and proposed remediations in its QIP, which center on addressing: expanding Re-Engineered Discharge (RED) with two additional mental health inpatient providers; "develop a joint operating agreement between facilities and mental health outpatient providers to ensure communications between the MH IP facilities, Members and MH OP providers and compliance with new value based purchasing requirements;" and	Timeliness, Access

Measure/Project	IPRO's Recommendation	Standards
	development and dissemination of resources and information related to telehealth and viable alternatives for members. PerformCare also noted a lack of engagement among both providers and members related to getting aftercare. IPRO recommends PerformCare leverage interviews, focus groups, member satisfaction surveys, and similar sources to drill deeper into the causes of this lack of engagement so that it can identify concrete interventions to address it.	
Readmission Within 30 Days of Inpatient Psychiatric Discharge	PerformCare's REA rates fell in MY 2021, led by its Franklin-Fulton contract. For its SUD PEDTAR PIP, PerformCare identified the subpopulation of members with co-occurring SUD and MH conditions as being at elevated risk for readmission, in part due to missed opportunities for coordinating care. PerformCare also identified a need to increase timely stepped-down care from detox, MAT penetration, as well as treatment retention rates, particularly among African-American members. An underlying barrier to improvement common to many of these areas related to SDoH. PerformCare's interventions will include the development and distribution to network-providers of a "toolbox of resources" centered on facilitating screenings, assessments, and referrals to appropriate levels and modalities of care, including the use of Certified Recovery Specialists (CRS). Guiding this implementation at PerformCare will be a dedicated team of BH specialists and clinicians monitoring provider data and informed by an "SU Evidence-Based Treatment Internal Resource Guide." PerformCare's multi-pronged approach to its PEDTAR PIP, starting with the development of internal data- and EBP-driven teams, places it in a strong position to improving outcomes for its members at risk for or afflicted with SUD. Its PEDTAR PIP may well serve as a model for bringing about similar improvements for its members, more generally. A next logical step is to conduct Difference in Difference (DiD) tests to compare rates of improvement in REA between members who carry an SUD diagnosis and those who don't to assess whether PIP interventions are being effective. Similar analysis could be conducted for members with SPMI who are participating in the ICP program (and compared to those who are not) to determine whether specific BH-PH integration interventions are also impacting REA.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Availability of services	PerformCare was noncompliant with one of the substandards concerned with denial letters. IPRO concurs with the corrective action plan finding that "PerformCare must institute a process to ensure that all denial letters include a) an individualized clinical rationale; and b) the [medical necessity criteria] MNC that was used to make the determination is accurately identified in the denial letter."	Quality, Access
Coordination and continuity of care	PerformCare was noncompliant with one of the substandards concerned with denial letters. IPRO concurs with the corrective action plan finding that "PerformCare must institute a process to ensure that all denial letters include a) an individualized clinical rationale; and b) the [medical necessity criteria] MNC that was used to make the determination is accurately identified in the denial letter."	Quality, Access
Coverage and authorization of services	For this BBA standard, PerformCare was noncompliant with a substandard requiring the medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. In addition to the above recommendation, IPRO concurs with the corrective plan finding that "PerformCare must ensure	Quality, Access

Measure/Project	IPRO's Recommendation	Standards
	the Denial rationale is easy to understand and free of medical jargon. They should ensure the reference to [medical necessity criteria] MNC in the rationale is consistent with the direction in OMHSAS' denial templates."	
Practice guidelines	For this BBA standard, PerformCare was noncompliant with a substandard requiring the medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. In addition to the above recommendation, IPRO concurs with the corrective plan finding that "PerformCare must ensure the Denial rationale is easy to understand and free of medical jargon. They should ensure the reference to [medical necessity criteria] MNC in the rationale is consistent with the direction in OMHSAS' denial templates."	Quality, Access
Grievance and appeal systems	PerformCare was partially compliant with three substandards related to their complaints process. IPRO concurs with OMHSAS' recommendations and CAPs: PerformCare must follow Appendix H; §B.2.l. requirements, specifically regarding the 1st Level Complaint process. The Member may elect not to attend the Complaint Review meeting; but the meeting must be conducted with the same protocols as if the Member was present. PerformCare should continue to ensure the rationales of Complaint letters are written in clear; easily understandable language in order to maintain at least a 90% compliance with this Standard. PerformCare should continue to ensure the list of member Complaints in the Acknowledgement Letter matches the list of member Complaints in the Decision Letter. PerformCare should continue to improve their internal processes to ensure that they are able to provide clear documentation in each case file as to whether follow-up or corrective action is necessary; and whether it was sufficiently completed.	Quality, Access

HealthChoices BH recommendations

As mentioned, there are many factors that influence a payer's performance in the major dimensions of healthcare quality, timeliness, and access, many of which are not directly controllable by the MCO. Specific factors and therefore recommendations apply to individual MCOs. Nevertheless, some factors cut across MCOs to include HealthChoices BH program-level considerations. Coordination of care planning and provisions remains a challenge for the BH-MCOs, perhaps particularly with respect to coordination with the physical health side of the HealthChoices program. Restrictions related to protecting confidentiality, especially for members with SUD, continue to present a barrier. Proposed changes to some of PA's State regulations may help to facilitate timely data-sharing while also protecting confidentiality. At the DHS level, the HealthChoices program should continue to seek ways to collaborate on solutions, including a DHS-hosted filesharing process that was recently put in place to allow BH- and PH-MCOs to share appropriately redacted member-level data files.

Pennsylvania's HealthChoices program should continue to develop incentives through PA PM-specific but also more "interdisciplinary" P4P programs like the PH-MCO and BH-MCO Integrated Care Plan (ICP) Program and the Integrated Community Wellness Clinics (ICWC) program, a CMS Waiver program overseen by OMHSAS. As it does, it should consider ways to continue to build the capacity of MCOs and their networks to calculate quality measures on their own. OMHSAS' recent move to require its BH-MCOs to use HEDIS certified software vendors to run its HEDIS FUH PM is a positive step in this direction. Building the capacity of MCOs and their networks to calculate quality measures on their own will enable plans to effectively monitor their QAPI programs and related initiatives on a more

continuous basis which will, in turn, position them to succeed in the VBP environment. Key, for payers, to achieving improved outcomes at lower costs is the ability to collect and analyze timely data to identify areas for improvement as well as reinvestment. Here, DHS should ensure that standards around meaningful use and health information technologies, including health information exchanges (HIEs), are up-to-date and reflected in MMC contracts. Finally, since the publication of the *2020 Medicaid and CHIP Managed Care Final Rule*, as well as the February 2023 CMS EQR Protocols, OMHSAS is actively reviewing its network adequacy monitoring program to ensure all relevant requirements are covered in the annual validation activity going forward. For behavioral health, those requirements include: quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[7] At the same time, PA should continue to support MMC MCOs through grants, technical assistance, or other means, in achieving these standards. For BH, at least, cooperation between DHS and the counties comprising the BH Primary Contractors will likely continue to be a linchpin in improving the quality, timeliness, and access to care within the HealthChoices program. Counties present natural sites for collaboration across PA departments and scopes which may help drive innovation, as DHS's Centers of Excellence program to combat opioid addiction through its collaboration with DDAP's Single County Authorities is demonstrating.

CHC-MCOs

Table 18 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2022 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures and CAHPS Survey, and Compliance with Medicaid and CHIP Managed Care Regulations.

Table 18: CHC-MCO 2022 EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
ACP CHC/KF CHC		
Performance Improvement Projects (PIPs)		
July 2022 PIP Submissions for Strengthening Care Coordination and Transition of Care from Nursing Facility to the Community	It is recommended that the MCO improve its capacity to submit PIP reports in accordance with the submission schedule.	Timeliness
Performance Measures and CAHPS Survey		
HEDIS Performance Measure Validation	It is recommended that the MCO work on improving their rates for several HEDIS performance measures in the Effectiveness of Care domain.	Access, Quality
PA-Specific Performance Measure Validation	It is recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		
KF CHC		
Performance Improvement Projects (PIPs)		
July 2022 PIP Submissions for Strengthening Care Coordination and Transition of Care from Nursing Facility to the Community	It is recommended that the MCO improve its capacity to submit PIP reports in accordance with the submission schedule.	Timeliness
Performance Measures and CAHPS Survey		

Measure/Project	IPRO's Recommendation	Standards
HEDIS Performance Measure Validation	It is recommended that the MCO work on improving their rates for several HEDIS performance measures in the Effectiveness of Care domain.	Access, Quality
PA-Specific Performance Measure Validation	It is recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		
PAHW CHC		
Performance Improvement Projects (PIPs)		
There are no recommendations related to compliance with PIPs for the MCO for the current review year.		
Performance Measures and CAHPS Survey		
HEDIS Performance Measure Validation	It is recommended that the MCO work on improving their rates for several HEDIS performance measures in the Effectiveness of Care and Access/Availability of Care domains.	Access, Quality
PA-Specific Performance Measure Validation	It is recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		
UPMC CHC		
Performance Improvement Projects (PIPs)		
July 2022 PIP Submissions for Strengthening Care Coordination and Transition of Care from Nursing Facility to the Community	It is recommended that the MCO improve data reporting capabilities to ensure accurate data is reported for PIP validation in accordance with the submission schedule.	Timeliness, Quality
Performance Measures and CAHPS Survey		
PA-Specific Performance Measure Validation	It is recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		

EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; MCO: managed care organization; PA: Pennsylvania; PM: performance measure; CFR: Code of Federal Regulations; RY: review year.

Section VI: Adult Community Autism Program (ACAP)

Introduction

The Adult Community Autism Program (ACAP) is a voluntary PIHP program approved under the authority of 1915(a) of the Social Security Act and is overseen by the Bureau of Supports for Autism and Special Populations (BSASP) within the Office of Developmental Programs. ACAP is designed to meet the needs of adults with an autism spectrum disorder. The program is administered under the "Agreement for the Adult Community Autism Program (ACAP)" ("Agreement") with Keystone Autism Services (KAS). KAS provides ambulatory medical services and long-term services and supports (LTSS) to the adults enrolled in the program. As of December 2021, 183 members were enrolled in the program.

Performance Improvement Project

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

Technical Methods of Data Collection and Analysis

A new PIP topic, "Reducing Social Isolation," was selected in 2018 that focuses on mitigating and overcoming social isolation among ACAP members. A Social Isolation Survey tool was developed based on work by the Patient-Reported Outcomes Measurement Information System (PROMIS®), a Northwestern University project funded by the National Institutes of Health, and by Temple University. The survey tool will be utilized on a quarterly basis to record members' perceptions of social isolation, companionship, and community participation. Baseline data were collected during the fourth quarter of 2018. KAS submitted a proposal entitled "Establishing Socially Valued Roles through Person Centered Planning to Reduce Social Isolation of Adults with Autism," in Spring 2019, which was accepted after a revision. The principal intervention features a person-centered social role valorization (SRV) model that sets goals for attaining socially valued roles (SVR). Intervention tracking measures (ITMs) center on measurement using a Goal Attainment Scale (GAS). Two performance indicators are based on the Social Isolation tool: a Social Isolation (SI) Index score which measures the average social isolation of ACAP members, and the percentage of members reporting feeling socially isolated. The PIP started in June 2019. PIP was scheduled to roll out in a staggered fashion to the entire membership over the course of the PIP.

KAS submitted their first annual PIP report in August 2020 which included reporting on the last 6 months of 2019. KAS noted that some progress had been made with respect to SVR goal attainment rates, as well as to the overall percent of members reporting social isolation (40%, down from 48% at baseline). However, results also showed that the mean SI index score did not improve from baseline (= 19). It was acknowledged that prioritizing participation in Year 1 to individuals with higher social isolation (n= 82 out of 179) may also have slowed progress toward the PIP's overall Year 1 goal for a mean SI score = 18.

IPRO noted some deficiencies in the annual reporting which complicated interpretation of results and next steps. No statistical tests were performed to evaluate significance of any observed differences in group means between those receiving the person-centered SRV intervention and those who had not yet started their participation in PIP. Most notably, threats to internal and external validity were found to be insufficiently addressed. Measurement validity of individual SI Survey items remains a concern as does the measurement of goal attainment of SRV goals, a key ITM. A BSASP audit of individual service plans (ISP) of ACAP members identified as participating in the PIP intervention revealed that in some instances "SRV goals" were being set which appeared to have little to do with socially valued roles. Threats to external validity were also insufficiently addressed related to several potential source of bias, including: selection bias, change in risk factor distributions associated with population turnover, and non-response bias. Non-response bias is particularly important given that the two PIP performance indicators carry denominator exclusion criteria related to completion of the eight SI-specific items. IPRO's review noted that without assessment of the impacts, if any, of these biases on the results, there is no valid basis to determine whether the PIP is making a difference with respect to reducing social isolation among the

ACAP members. KAS was asked to address these deficiencies in its mid-year and annual reporting going forward. Review of Year 2 revealed persistent deficiencies that resulted in an extension of the PIP by one year and a corrective action plan (CAP) to address noted deficiencies.

2021 coincided with Year 3 of the PIP but due to the extension was treated as a second year to establish "Demonstrable Improvement." Like last year, the Year 3 review, completed in 2022 adhered to a formal scoring matrix which includes provisions for requiring a CAP if the report scores below 85%. IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (Updated: *Validating Performance Improvement Projects, Final Protocol, Version 2.0, September* 2012) and meets the requirements of the updated final rule on External Quality Review (EQR) of Medicaid Managed Care Organizations issued on May 6, 2016. IPRO's review of the ACAP PIP evaluates the project against 8 elements:

1. Project Topic and Rationale,
2. Aim Statement,
3. Methodology,
4. Barrier Analysis,
5. Robust Interventions
6. Results Table
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. IPRO's scoring for each element is based on full, partial, and non-compliance status. At the time each element is reviewed, a finding is given of met, partially met, or not met. Elements receiving a finding of met will receive 100% of the points assigned to the element, partially met elements will receive 50% of the assigned points, and not met elements will receive 0%. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. The review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance).

Findings

Table 19 presents the findings of IPRO's review of KAS' ACAP PIP for Year 3.

Table 19: KAS ACAP Reducing Social Isolation PIP (Extension) Year 3 Findings

Element	Score (with weight)
Project Topic and Rationale	Met (5%)
Aim Statement	Met (5%)
Methodology	Partial Met (7.5%)
Barrier Analysis	Partial Met (7.5%)
Robust Interventions	Partial Met (7.5%)
Results Table	Met (5%)
Discussion and Validity of Reported Improvement	Partial Met (10%)
Sustainability	N/A
TOTAL	47.5 (out of 80)
Overall Rating	59% (Not Met)

Overall, the PIP score for the third year report remained unchanged from the previous year at 59%. Although KAS made some improvements to its reporting, including some improvement in response rates, many of the same issues identified in the first and second year reports continued. In light of previous year's extensions, BSASP moved to replace a CAP with a change in the study design. KAS proposed to both refine their GAS and switch to a single case design measuring average improvement using a Percent Nonoverlapping Data (PND) method. Additional education and training on SRV was provided to its Behavioral Health Specialists (BHSs), Supports Coordinators (SCs) and related support staff, along with increased clinical oversight by the Quality Manager and Clinical Director. In response to methodological concerns around measuring improvement in its social isolation performance indicators, KAS also formalized and implemented a 10-step process for defining and achieving socially valued roles through the PCP process. However, the review noted that the formal education and training intervention around the new process was limited to April and May of 2021. IPRO cautioned KAS against prematurely concluding that this intervention had achieved its full effect and recommended KAS continue with the education and training intervention and monitor it using effective ITMs concerned with measuring activities as well as downstream learning outcomes, for example, via the Service Review Form (SRF), or similar periodic internal quality reviews.

KAS noted a general improvement from baseline through Year 3 on SI index scores for all members, particularly for those who received the PIP person-centered planning intervention for at least one quarter. A Difference-in-Difference (DiD) plot also suggested the possibility of a slight treatment effect. There may however be characteristics associated with the self-selected treatment cohort which correlate with improvement, and this self-selection bias cannot be more fully tested until all ACAP members participate in the PIP intervention. As of the end of 2021, 117 out 183 members, or roughly 64%, had participated in the PIP, of which 56.4% had undergone the full 10-step SRV process. IPRO urged KAS to accelerate member participation rates in the PIP, noting that the PIP's intent and design called for full participation by the conclusion of the PIP in summer 2023.

Performance Measures

Objectives

In MY 2021, BSASP required KAS to calculate and report performance measures as part of their quality assessment and performance improvement (QAPI) program. IPRO validated all performance measures reported by the PIHP for MY 2021 to ensure that the performance measures were implemented according to specifications and state reporting requirements (42 C.F.R. § 438.330(b)(2).

Technical Methods of Data Collection and Analysis

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

For MY 2021, seven performance measures were used by BSASP to monitor KAS' QAPI program with respect to key health outcomes and for which benchmarks were established:

1. Law Enforcement Incidents
2. Behavioral Health Crisis Events
3. Psychiatric Hospitalization Follow-up
4. (Timeliness of) Initial Primary Care Physician (PCP) Visit
5. Annual Dental Exam
6. Competitive Employment

7. Hours Worked

Annual results were submitted by KAS to BSASP in their annual ACAP BSASP Report. As part of its annual compliance review, BSASP reviewed documentation related to KAS' tracking and reporting of the five performance measures. KAS submitted to BSASP documentation which included a description of changes to the methodology used to measure quality. BSASP also reviewed records along with three reports presented to KAS' QAPI Governing Body: Annual (QAPI) Report, Employee Report, and Incident Management Report. KAS was found partially compliant with requirements related to QAPI reporting.

Findings

MY 2021 results are reported in **Table 20**.

Table 20: ACAP Results for 2022 (MY 2021) Performance Measures

Performance Measure	Benchmark	Rate
Law Enforcement Incidents	95% of all individuals will reduce or maintain, if at zero, their number of law enforcement incidents (charged with a crime or under police investigation) as compared to baseline	98% (174/177)
Behavioral Health Crisis Events	95% of all individuals will reduce or maintain, if at zero, their number of behavioral health crisis events as compared to baseline	95% (168 of 177)
Psychiatric Hospitalization Follow-up	95% of all psychiatric hospitalizations will be followed by a psychiatric or PCP visit within 30 days	57% (4 of 7) of psychiatric hospitalizations*
(Timeliness of) Initial Primary Care Physician (PCP) Visit	95% of all new enrollees will have an initial visit with a PCP within 3 months prior to enrollment or within 3 weeks after enrollment	100% of new enrollees (6 of 6)
Annual Dental Exam	90% of all participants will have a dental exam each calendar year	76% (135 of 177)
Competitive Employment	56% of participants will be employed	57% (104 of 183) of participants were employed in December 2021
Hours Worked	90% of those individuals who worked will increase or maintain number of hours worked	64% (74 of 115) of participants

* One of the three psychiatric discharges not meeting the numerator was re-hospitalized within the 30-day period. Excluding this discharge from the denominator renders a rate of 4/6 = 67%.

KAS Compliance with Medicaid Managed Care Regulations

Objectives

This section of the EQR report presents a review by IPRO of the PIHP's compliance with the MMC structure and operations standards. In accordance with the updates to the CMS EQRO Protocols released in late 2019,[8] IPRO updated the organization and content of this section. The CMS updates included updates to the 11 BBA standards which are now required for reporting. The standards that are subject to EQR review are contained in 42 C.F.R. 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E.

Technical Methods of Data Collection and Analysis

In a break from previous years, IPRO carried out the 2021 compliance review of the PIHP in 2022. The 11 required standards covering these Subparts are comprised of 32 CMS review elements which were furthermore crosswalked to pertinent standards defined in the ACAP Contract, or "Agreement." Compliance review consisted of the PIHP submitting requested documentation (including case review files), a process which underwent several iterations to ensure relevance and completeness of information, followed by a desk review by IPRO and finally a virtual video conference with KAS leadership and staff consisting of document and system reviews and informal interviews. The only exception to this review process was the review for the remaining CMS review element, Performance Improvement Projects (per 42 C.F.R. § 438.330(d)), which was based on the Year 3 Annual Report review conducted by IPRO earlier in 2022.

Both BSASP and KAS had the opportunity review initial compliance review determinations and respond with clarifications before final determinations were made.

Findings

Tabulated findings are formatted to be consistent with the subparts prescribed by the BBA regulations. In addition, findings for RY 2021 are presented here under the three "CMS sections" headings: Standards, including Enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up were also produced. Applicable regulatory requirements are summarized under each programs' subsections, consistent with the applicable subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol.*

Table 21 summarizes the compliance review determinations across the 11 BBA MMC standards with tallies of the applicable compliance review elements that were used, by finding. Compliance level of "Met," "Partially Met," and "Not Met" were used. Separate tallies are provided for elements that are not applicable ("N/A") or deemed compliant from a secondary source review, such as an NCQA-accreditation("Deemed").

Table 21: KAS Compliance with MMC standards in RY 2021

MMC Standard	Compliance Status	N/A	Deemed	Met	Partially Met	Not Met
Standards, including enrollee rights and protections						
Assurances of adequate capacity and services (42 C.F.R. § 438.207)	Partially Met	0	0	6	12	4
Availability of services (42 C.F.R § 438.206, 42 C.F.R. § 10(h))	Partially Met	1	0	9	13	3
Coordination and continuity of care (42 C.F.R. § 438.208)	Partially Met	0	0	50	18	28
Coverage and authorization of services (42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114)	Partially Met	0	0	31	32	10
Enrollee rights and protection (42 C.F.R. § 438.224)	Partially Met	13	0	57	6	2
Health information systems (42 C.F.R. § 438.242)	Partially Met	0	0	3	1	0

MMC Standard	Compliance Status	N/A	Deemed	Met	Partially Met	Not Met
Practice guidelines (42 C.F.R. § 438.236)	Partially Met	0	0	4	3	1
Provider selection (42 C.F.R. § 438.214)	Partially Met	0	0	7	32	2
Subcontractual relationships and delegation (42 C.F.R. § 438.230)	N/A	5	0	0	0	0
Quality assessment and performance improvement (QAPI) program						
Quality assessment and performance improvement program (42 C.F.R. § 438.330)	Partially Met	0	0	6	16	1
Grievance system						
Grievance and appeal systems (42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424)	Partially Met	0	0	42	0	1

KAS was found partially compliant with eight of the nine standards within Standards, including enrollee rights and protections. A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. Case management file reviews also revealed some specific opportunities for improvement. Under Coordination and continuity of care, it was noted that KAS should ensure that Medication Therapeutic Management Plans are developed for members with four (4) or more psychotropic medications. For Coverage and authorization of services, IPRO recommended KAS stand up a tracking mechanism for all elements of authorization cases including timeliness, information on phone calls, and all correspondence. For some of the deficiencies under Enrollee Rights and Protections, it was noted that remediation may in certain circumstances—for example, providing public-facing information on network adequacy standards to potential enrollees—require coordination with BSASP, possibly including updates to the existing Contract, to ensure alignment. The current Agreement prohibits KAS from delegating any functions; KAS was therefore exempt from review for Subcontractual relationships and delegation.

KAS was partially compliant with QAPI. In a theme that cut across all three major compliance areas, many deficiencies center on a lack of formal policies, procedures, or plans. It was noted that KAS needed to update its QAPI plan to measure, evaluate, and monitor quality areas as outlined in the Agreement. Among other things, KAS should expand utilization reporting to all services including medical and BH services provided in the larger network, and should cover all utilization, not just those above a certain threshold. This means developing methods for detecting over-, under-, and misutilization for services covered (i.e., paid for, either in part or in full), and not just provided, by KAS. Finally, the monitoring mechanism should be formalized in writing, as part of its QAPI plan. Related to this, it was noted that no audits of medical and support service records had been conducted by KAS in 2021, as required in the Agreement. The review furthermore recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement. Other recommendations centered on governance. KAS should implement a formal governance process that ensures that adequate support, including staff and alternative forms of communication, is provided to the Participant Committee and its report-out to the Member Advisory Committee (MAC). Furthermore, KAS should implement a formal governance process that ensures that adequate support is provided by the MAC to the Quality Management and Utilization Review Committee(s) and furthermore that the MAC is accountable to the relevant governing body for issues addressed by the Quality Management and Utilization Review Committee(s). Finally, KAS should implement a formal policy that the Quality Management and Utilization Review Committee provide guidance and assistance to support KAS in carrying out the relevant quality management responsibilities specified as specified in the Agreement. Documentation should show follow-through that reflects the guidance and assistance was taken into consideration and utilized.

Of note, several recommendations related to QAPI were also submitted to BSASP. IPRO's assessment is that the ACAP PIHPs, in this case KAS, fit the definition of "providing long-term services and supports," as provided under 42 CFR 438.330(c)(1)(ii). As such, a recommendation from the MY 2021 findings is that BSASP should add relevant LTSS PM(s) to its QAPI PM reporting requirements. In fact, BSASP did update its PM measure set in MY 2022, and they continue to explore PM development that will meet both Federal standards as well as State Quality Strategy and ACAP goals. More generally, IPRO recommends the Agreement continue to be updated to reflect changes in both Federal and BSASP standards, including as they pertain to PIPs.

KAS was partially compliant with all requirements associated with Grievance system. Consistent with the general theme of formalizing policies, it was recommended that KAS add to the Compliant and Grievance Procedure and the Participant Handbook that clarifies a requirement regarding filing a discrimination complaint with the Office of Civil Rights. KAS should furthermore coordinate with BSASP to ensure the requirement language aligns with the standard State MCO Handbook currently in use.

Assessment of Quality, Timeliness, and Access

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

Table 22 details the full list of recommendations that are made for the MCO for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for the year. The PIP recommendations may include issues from prior years if they remain unresolved. For performance measures, the strengths and opportunities noted above in this section are determined for the current year, while recommendations are based on issues that were not only identified as opportunities for the current 2022 (MY 2021) year but were also identified as outstanding opportunities from 2021 (MY 2020).

Table 22: ACAP EQR Findings and Recommendations

Measure/Project	MY 2020 Recommendations	MY 2021 Finding	MY 2021 Recommendations	Domains
Performance Improvement Projects (PIPs)				
	• Methodology – KAS should formalize a methodological framework for implementing a robust SRV model within the context of person-centered planning, which will include development of standard protocols for defining a socially valued role (SVR) and associated objectives as well as measurement of progress on those objectives and SVR. • Barrier Analysis and Robust Interventions – Once formalized, the methodological framework should inform evidence-based	Overall, the PIP score for the third year report remained unchanged from the previous year at 59%. Although KAS made some improvements to its reporting, including some improvement in response rates, many of the same issues identified in the first and second year reports continued. In response, KAS proposed to both refine their GAS and switch to a single case design measuring average improvement using a Percent Nonoverlapping Data (PND) method. Additional education and training on SRV was	The review noted that the formal education and training intervention around the new process was limited to April and May of 2021. IPRO cautioned KAS against prematurely concluding that this intervention had achieved its full effect and recommended KAS continue with the education and training intervention and monitor it using effective ITMs concerned with measuring activities as well as downstream learning outcomes, for example, via the Service Review Form (SRF), or similar periodic internal quality	Quality, Timeliness, Access

Measure/Project	MY 2020 Recommendations	MY 2021 Finding	MY 2021 Recommendations	Domains
	SRV practices and strategies, and associated trainings, for care planning (including skill-building) and provision. • Discussion and Validity of Reported Improvement – Remediations for the above deficiencies, including enhancement of ITMs to measure implementation fidelity of the PIP, are expected to also address noted deficiencies in discussion and validity of reported improvements. A Difference-in-Difference (DiD) method was also proposed to control for counterfactuals in measurement of "treatment" (intervention) effect.	provided to its Behavioral Health Specialists (BHSs), Supports Coordinators (SCs) and related support staff, along with increased clinical oversight by the Quality Manager and Clinical Director. In response to methodological concerns around measuring improvement in its social isolation performance indicators, KAS also formalized and implemented a 10-step process for defining and achieving socially valued roles through the PCP process.	reviews. Improvement on the performance indicators has not yet been demonstrated. There may be characteristics associated with the self-selected treatment cohort which correlate with improvement, and this self-selection bias cannot be more fully tested until all ACAP members participate in the PIP intervention. As of the end of 2021, 117 out 183 members, or roughly 64%, had participated in the PIP, of which 56.4% had undergone the full 10-step SRV process. IPRO urged KAS to accelerate member participation rates in the PIP, noting that the PIP's intent and design called for full participation by the conclusion of the PIP in summer 2023.	
Performance Measures				
	KAS should continue to look for ways to streamline recordkeeping, including linking data sources and systems to more automatically update changes...These improvements can also be expected to foster improvements in the Performance Measures and PIP requirements, the other area where KAS was not compliant.	In the case of many of the performance measures, changes were introduced to the methodology, which included an increased use of percentages and rates to facilitate more meaningful year-over-year comparisons. In most of these cases, new benchmarks and accompanying baselines were set.	BSASP should add relevant LTSS PM(s) to its QAPI PM reporting requirements. It was noted that KAS needed to update its QAPI plan to measure, evaluate, and monitor quality areas as outlined in the Agreement (Appendix K).	Timeliness, Access
Compliance with Medicaid Managed Care Regulations				
Assurances of adequate capacity and services	None given	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements.	Formalize policies, procedures, and plans.	Quality, Timeliness, Access

Measure/Project	MY 2020 Recommendations	MY 2021 Finding	MY 2021 Recommendations	Domains
Availability of Services	KAS should continue to look for ways to streamline recordkeeping, including linking data sources and systems to more automatically update changes, which will enable KAS, despite continuing staff shortages and turnover, to address the opportunities for improvement	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements.	Formalize policies, procedures, and plans. The review furthermore recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement.	Quality, Timeliness, Access
Coordination and continuity of care	Integration of information is not always consistent, with critical information from assessments, particularly those related to risks, not being reflected in Individual Service Plans (ISPs).	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements.	Formalize policies, procedures, and plans. KAS should ensure that Medication Therapeutic Management Plans are developed for members with four (4) or more psychotropic medications. The monitoring mechanism should be formalized in writing, as part of its QAPI plan. Related to this, it was noted that no audits of medical and support service records had been conducted by KAS in 2021, as required in the Agreement. The review furthermore recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement.	Quality, Timeliness, Access
Coverage and authorization of services	KAS should continue to look for ways to streamline recordkeeping, including linking data sources and systems to more automatically update changes, which will enable KAS, despite continuing staff shortages and turnover, to address the opportunities for improvement	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements.	KAS should stand up a tracking mechanism for all elements of authorization cases including timeliness, information on phone calls, and all correspondence.	Timeliness, Access
Enrollee rights and protection	None given	A majority of the deficiencies noted across the standard areas centered on lack of formal policies,	Remediation may in certain circumstances—for example, providing public-facing information on network adequacy standards to	Quality, Timeliness, Access

Measure/Project	MY 2020 Recommendations	MY 2021 Finding	MY 2021 Recommendations	Domains
		procedures, or plans to ensure compliance with requirements.	potential enrollees—require coordination with BSASP, possibly including updates to the existing Contract, to ensure alignment.	
Health information systems	KAS should continue to look for ways to streamline recordkeeping, including linking data sources and systems to more automatically update changes, which will enable KAS, despite continuing staff shortages and turnover, to address the opportunities for improvement	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements.	Formalize policies, procedures, and plans.	Quality
Practice guidelines	None given	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements.	Formalize policies, procedures, and plans.	Quality, Timeliness, Access
Provider selection	None given	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements.	Formalize policies, procedures, and plans.	Quality, Timeliness, Access
Quality assessment and performance improvement program	For 2020, BSASP noted a general decrease in the quality of the audited ISPs when compared with MY 2019, reversing the improvement noted in MY 2019. Some improvements, however, did continue, including in the Functional Information component, which assesses whether the ISP reflects strengths and needs as identified on the Scales of Independent Behavior-Revised (SIBR) assessment. BSASP identified a lack of documentation related to risks and risk mitigation strategies as the primary area of weakness associated	Many of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS needs to update its QAPI plan to measure, evaluate, and monitor quality areas as outlined in the Agreement (Appendix K). Related to this, it was noted that no audits of medical and support service records had been conducted by KAS in 2021, as required in the Agreement.	Among other things, KAS should expand utilization reporting to all services including medical and BH services provided in the larger network, and should cover all utilization, not just those above a certain threshold. This means developing methods for detecting over-, under-, and misutilization for services covered (i.e., paid for, either in part or in full), and not just provided, by KAS. Finally, the monitoring mechanism should be formalized in writing, as part of its QAPI plan. The review furthermore	Quality, Timeliness, Access

Measure/Project	MY 2020 Recommendations	MY 2021 Finding	MY 2021 Recommendations	Domains
	with ISPs, although other quality areas such as timely Periodic Risk Evaluations (PREs) at intake, also worsened from MY 2019.		recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement. Other recommendations centered on governance. KAS should implement a formal governance process that ensures that adequate support, including staff and alternative forms of communication, is provided to the Participant Committee and its report-out to the Member Advisory Committee (MAC). Furthermore, KAS should implement a formal governance process that ensures that adequate support is provided by the MAC to the Quality Management and Utilization Review Committee(s) and furthermore that the MAC is accountable to the relevant governing body. for issues addressed by the Quality Management and Utilization Review Committee(s). Finally, KAS should implement a formal policy that the Quality Management and Utilization Review Committee provide guidance and assistance to support KAS in carrying out the relevant quality management responsibilities specified as specified in the Agreement. Documentation should show follow-through that reflects the	

Measure/Project	MY 2020 Recommendations	MY 2021 Finding	MY 2021 Recommendations	Domains
			guidance and assistance was taken into consideration and utilized.	
Grievance and appeal systems	KAS should continue to look for ways to streamline recordkeeping, including linking data sources and systems to more automatically update changes, which will enable KAS, despite continuing staff shortages and turnover, to address the opportunities for improvement	KAS did not include clarify in the Compliant and Grievance Procedure and the Participant Handbook a requirement regarding filing a discrimination complaint with the Office of Civil Rights.	KAS should add to the Compliant and Grievance Procedure and the Participant Handbook that clarifies a requirement regarding filing a discrimination complaint with the Office of Civil Rights. KAS should furthermore coordinate with BSASP to ensure the requirement language aligns with the standard State MCO Handbook currently in use.	Quality, Timeliness, Access

IPRO's Assessment of the Pennsylvania Managed Care Quality Strategy

Managed Care Quality Strategy, 2020

Pennsylvania's current Quality Strategy, Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy,[9] dated December 2020 was developed with input from stakeholders. The Quality Strategy includes objectives, standards, and goals for the following overarching areas that impact health care services: network adequacy and availability; continuous quality improvement (QI); quality metrics and performance targets; PIPs; external independent reviews; Transitions of Care; health disparities; intermediate sanctions; long-term services and supports (LTSS); and non-duplication of EQR activities.

Goals and Objectives

Pennsylvania's Managed Care goals and objectives align with the mission, vision, and values of DHS. Each Medicaid managed care program has unique specific goals and objectives, but they all relate back to DHS's overarching priorities. These goals are listed in **Table 23**.

Table 23: Pennsylvania's Managed Care Quality Strategy Goals, 2020

Pennsylvania's Managed Care Goals
1. Increase access to healthcare services 2. Improve quality of healthcare services 3. Bend the healthcare cost curve

The state's objectives for HealthChoices and CHIP track progress toward achieving established goals, as well as identifying opportunities for improvement. There are sub-objectives across the five program offices within each of these three overarching goals:

Access to Healthcare Services:

- Monitoring of Provider Network Adequacy.
- Building a Medicaid Program Oversight Portal and CHIP Program Oversight Portal
- Monitoring MCO credentialing
- Implementation of a uniform statewide Preferred Drug List
- Monitoring Compliance with Standards, especially
    1. Access and Operations
    2. Special Needs
    3. Cultural Competency

Quality of Healthcare Services

- Oversight of the MCOs
    1. Monitoring
    2. Sanctions
- Framework for Quality Improvement
    1. Quality Management Program
    2. Member Satisfaction
    3. Performance Improvement Projects

4. Performance Measures
5. Pay for Performance
6. Health Equity
7. External Quality Review

Bending the Cost Curve

- Value Based Payments
- Efficiency Adjustments
- Health Information Technology

Methodology

For this assessment, IPRO utilized the rubric from the CMS Medicaid and CHIP Managed Care: Quality Strategy Toolkit Summary, June 2021 as well as the contents of C.F.R. 438.340 in reviewing the Pennsylvania Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy dated December 2020.

Observations

Structure of programs for physical health, behavioral health, CHIP and LTSS/HCBS are all addressed in detail including the regional approach, the number, and types of plans. DHS describes its process for seeking input from qualified stakeholders in developing its quality strategy. Stakeholders identified include: Medicaid members, the public, Medicaid Assistance Advisory Committee, County Administrators Advisory Committee, Pennsylvania Mental Health Planning Council, Children's Health Advisory Council, Information Sharing and Advisory Committee, and MCOs.

There is high-level discussion of Goals, Monitoring QAPI at the MCO level, Sanctions, and Incentive programs. DHS also discusses its public-facing MPOP dashboard plans, while Cultural Competency and Social Determinants of Health/Health Equity are also discussed at a high level. Additionally, DHS invites input from its external stakeholders regarding requirements established for MCO collection of data at the level of race, ethnicity and language and analysis of performance measures at this level.

There is a detailed list of objectives in terms of access and availability of services. However, there is no discussion of the current state of access and availability at the program or plan level, or discussion of actions being undertaken to address any gaps if applicable. There is no discussion of the PA results on any measures in comparison to identified peers or national averages.

There is a section on Performance Improvement Project (PIPs). However, it is very high level and does not provide a description of any interventions it proposes to improve access, quality, or timeliness of care. EQRO validation of PIPs is discussed in detail in Section I of this report.

There is a section on transitions of care. However, this section focuses exclusively on transition of members between MCOs and contains no other discussion of transitions between care settings or levels of care.

There is a list of performance measures in use in the monitoring of quality. However, there is no discussion of results, no identification of any underperformance at the program or MCO level, and no discussion of activities undertaken to address underperformance. EQRO validation of Performance Measures is discussed in detail in Section II of this report.

There is no listing of any current MCO sanctions or discussion of prior sanctions within the past three years and how those are being monitored. If any sanctions or corrective actions plans (CAPS) were instated at either the MCO or aggregate level in the past three years, they should be described in the Quality Strategy, and the causes for those actions should be described as well. Any sanctions or CAPS should be updated based on ongoing monitoring of performance against the goals set out in the sanctions and/or CAPs.

Pennsylvania's quality management plan and execution is robust, particularly with regard to the adoption of CMS core measures and an ambitious program to create quality dashboards through the MPOP project. Initiatives that target health equity, social determinants of health, and health information are all forward-looking and expansive. DHS is using the levers available through pay for performance programs to align quality and efficiency within the delivery systems.

Recommendations

As the current Quality Strategy was published December 2020, it is anticipated that a new strategy will be published in 2023.

IPRO recommends that the next iteration of the Quality Strategy contain the following additions to align more fully with the CMS standards set forth.

- Goals for quality outcomes as captured in performance measures should have numeric targets either in absolute or rate of improvement expressions.
- Specific discussions of quality metrics in the context of a peer group (similar state programs), national averages and comparison of MCOs should be included.
- The discussion of PIPs could include more information about the experience of the MCOs and the impact the individual projects are having on quality outcomes for the members across the state. It should also include a description of any interventions it proposes to improve access, quality, or timeliness of care.
- Any gaps in access to care should be addressed and plans to close those gaps discussed.
- An updated discussion of its network adequacy monitoring program to ensure quality goals align with all relevant network adequacy requirements

Final Project Reports

Upon request, the following reports can be made available:

1. Individual PH-MCO Annual Technical Reports for 2022
2. Individual CHIP-MCO Annual Technical Reports for 2022
3. Individual BH-MCO Annual Technical Reports for 2021
4. Individual CHC-MCO Annual Technical Reports for 2022
5. Follow-up After Hospitalization for Mental Illness External Quality Review Rates Report (BH-MCOs)
6. Readmission Within 30 Days of Inpatient Psychiatric Discharge External Quality Review Rates Report (BH-MCOs)
7. HEDIS MY 2021 Member-Level Data Reports, Data Analysis Trends (PH-MCOs)
8. HEDIS MY 2021 Member-Level Data Reports, Data Findings by Measure (PH-MCOs)
9. HEDIS MY 2021 Member-Level Data Reports, Year-to-Year Data Findings – Southeast Zone/Region (PH-MCOs)
10. HEDIS MY 2021 Member-Level Data Reports, Year-to-Year Data Findings – Southwest Zone/Region (PH-MCOs)
11. HEDIS MY 2021 Member-Level Data Reports, Year-to-Year Data Findings – Lehigh/Capital Zone/Region (PH-MCOs)
12. HEDIS MY 2021 Member-Level Data Reports, Year-to-Year Data Findings – New West Zone/Region (PH-MCOs)
13. Medicaid Managed Care (MMC) Performance Measures, Examination of Year-to-Year Statistical Comparisons for MMC Weighted Averages (PH-MCOs)
14. Medicaid Managed Care Performance Measure Matrices (PH-MCOs)
15. Medicaid Managed Care (MMC) Performance Measures, Examination of Year-to-Year Statistical Comparisons for MMC Weighted Averages (BH-MCOs)
16. 2021 HealthChoices Behavioral Health Balanced Scorecard (BH-MCOs)
17. 2022 PA CHIP CAHPS 5.1 Rate Table and Results by Item
18. 2022 CHIP Report Card

Note:
Reports 5 through 8 display data by MMC, BH-MCO, HealthChoices Behavioral Health Contractors (reports 5 and 6 only), County, Region (except for report 7), Gender, Age, Race, and Ethnicity.
Reports 9 through 14 display data by MMC, PH-MCO, Region, Race, and Ethnicity.
Reports 3, 5, 6, 15, and 16 includes results by HealthChoices Behavioral Health Contractors

References and Notes

[1] ACP CHC/KF CHC are affiliated under a single, parent CHC MCO.

[2] https://jamanetwork.com/journals/jamapediatrics/article-abstract/2784260

[3] https://www.cdc.gov/nceh/lead/docs/cbls-national-data-table-508.pdf

[4] National Committee for Quality Assurance (NCQA). (2021). *HEDIS® volume 2: Technical specifications for health plans.* NCQA. https://store.ncqa.org/hedis-2021-volume-2-epub.html.

[5] National Quality Forum (NQF). (2021, August 12). 3400: Use of pharmacotherapy for opioid use disorder (OUD). *Quality positioning system (QPS) measure description display information. http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=3400&print=0&entityTypeID=1.*

[6] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols October 2019* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[7] Luke Horner, Jung Kim, Megan Dormond, Kiana Hardy, Jenna Libersky, Debra J. Lipson, Mynti Hossain, and Amanda Lechner (2020). *Behavioral Health Provider Network Adequacy Toolkit*. Baltimore, MD: Division of Managed Care Policy, Center for Medicaid and CHIP Services, CMS, U.S. Department of Health and Human Services.

[8] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf .

[9] https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/Medical%20Assistance%20Quality%20Strategy%20for%20Pennsylvania.pdf .