



**Commonwealth of Pennsylvania
Department of Human Services
2018 External Quality Review Report
Statewide Medicaid Managed Care Annual Report**

FINAL REPORT

May 2019



Better healthcare,
realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO
9001:2008
CERTIFIED

Table of Contents

Overview	4
Introduction and Purpose.....	8
Information Sources	8
Section I: Compliance with Structure and Operations Standards.....	10
Evaluation of PH-MCO Compliance	10
Evaluation of CHIP-MCO Compliance	10
Evaluation of BH-MCO Compliance	11
Evaluation of CHC-MCO Compliance	13
Subpart C: Enrollee Rights and Protections.....	14
Subpart D: Quality Assessment and Performance Improvement Regulations.....	17
Subpart F: Federal and State Grievance System Standards	21
Subpart H: Certification and Program Integrity (CHIP).....	23
Readiness Review (CHC)	24
Section II: Performance Improvement Projects	26
Overall Project Performance Score	26
Scoring Matrix.....	27
PH-MCO PIP Review.....	27
CHIP MCO PIP Review	31
BH-MCO PIP Review	33
CHC-MCO PIP Review	36
Section III: Performance Measures	39
PH-MCO Performance Measures.....	39
CHIP-MCO Performance Measures	55
BH-MCO Performance Measures	64
CHC-MCO Performance Measures	65
Findings for CHC.....	69
Section IV: 2017 Opportunities for Improvement – MCO Response	70
Section V: 2018 Strengths and Opportunities for Improvement	71
Overall Strengths	71
Overall Opportunities	71
Section VI: 2017 Adult Community Autism Program (ACAP)	74
Performance Improvement Project.....	74
Performance Measures	74
Annual Monitoring.....	75
Final Project Reports.....	78

List of Tables

Table 1a: PH-MCO Compliance with Subpart C – Enrollee Rights and Protections Regulations.....	14
Table 1b: CHIP-MCO Compliance with Subpart C – Enrollee Rights and Protections Regulations.....	15
Table 1c: BH-MCO Compliance with Subpart C – Enrollee Rights and Protections Regulations.....	17
Table 2a: PH-MCO Compliance with Subpart D – Quality Assessment and Performance Improvement Regulations.....	18
Table 2b: CHIP-MCO Compliance with Subpart D – Quality Assessment and Performance Improvement Regulations.....	19
Table 2c: BH-MCO Compliance with Subpart D – Quality Assessment and Performance Improvement Regulations.....	20
Table 3a: PH-MCO Compliance with Subpart F – Federal and State Grievance System Standards.....	21
Table 3b: BH-MCO Compliance with Subpart F – Federal and State Grievance System Standards.....	22
Table 4: CHIP-MCO Compliance with Subpart H – Certification and Program Integrity.....	23
Table 5: CHC-MCO Readiness Review: Compliance with Structure and Operations Standards.....	24
Table 6a: PIP Review Element Scoring Weights.....	27
Table 6b: PH-MCO PIP Review Score – Improving Access to Pediatric Preventive Dental Care.....	30
Table 6c: PH-MCO PIP Review Score – Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits.....	30
Table 6d: CHIP-MCO PIP Review Score – Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years.....	33
Table 6e: CHIP-MCO PIP Review Score – Improving Blood Lead Screening Rates in Children 2 Years of Age.....	33
Table 6f: BH-MCO PIP Review Score – Successful Transition from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis.....	36
Table 6g: CHC-MCO PIP Proposal Review Score – Strengthening Care Coordination.....	38
Table 6h: CHC-MCO PIP Proposal Review Score – Transitions of Care from the Nursing Facility to the Community.....	38
Table 7: PH-MCO HEDIS 2018 Measure Results.....	39
Table 8: PH-MCO PA Performance Measure 2018 Results.....	50
Table 9: CHIP-MCO HEDIS 2018 Measure Results.....	55
Table 10: CHIP-MCO PA Performance Measure 2018 (Measurement Year 2017) Results.....	63
Table 11: BH-MCO Performance Measure Results for Measurement Year 2017.....	64
Table 12: PH-MCO Root Cause Analysis Measures 2018 (Measurement Year 2017).....	72
Table 13: BH-MCO Root Cause Analysis Measures – HEDIS 2018 Indicators.....	73
Table 14: ACAP Performance Measure Results for Measurement Year 2017.....	74

<p>HEDIS® and The Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). NCQA™ is a trademark of the National Committee for Quality Assurance.</p>
--

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 147 members enrolled as of December 2017, and EQR findings for this program are presented in a separate section within this report.

Pennsylvania MMC services are administered separately for PH services, for BH services, for CHIP services, for autism services, and for CHC services, 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 CHC.

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. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. Through these BH-MCOs, recipients receive mental health and/or drug and alcohol 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. With the expansion completed, HealthChoices PH served nearly 2.3 million recipients in 2018.

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 2018, Medical Assistance enrollees had a choice of three to five PH-MCOs within their county (depending on the zone of residence).

The HealthChoices BH Program differs from the PH component in that, for mental health and drug and alcohol services, each county/HC BH contractor contracts with one BH-MCO to provide services to all enrollees residing in that county. The HealthChoices BH Program is also mandatory statewide.

The MCOs that were participating in the HealthChoices Program as of December 2018 were:

Physical Health MCOs

- Aetna Better Health (ABH),
- AmeriHealth NorthEast (ACN),
- AmeriHealth Caritas Pennsylvania (ACP),
- Geisinger Health Plan (GEI),
- Gateway Health(GH),
- Health Partners Plan (HPP),
- Keystone First (KF),
- United Healthcare Community Plan (UHC), and
- UPMC for You (UPMC).

Behavioral Health MCOs

- Community Behavioral Health (CBH),
- Community Care Behavioral Health (CCBH),
- Magellan Behavioral Health (MBH),
- PerformCare, and
- Value Behavioral Health (VBH).

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. Currently, federal funds pay approximately 90% of CHIP’s total cost. CHIPRA contained numerous new federal program requirements, including citizenship and identity verification, a mandate to provide coverage for orthodontic services, 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 following 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:

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).

CHC is the mandatory managed care program for adults dually eligible for Medicare and Medicaid, and for older adults and adults with physical disabilities in need of long-term services and supports. Long-term services and supports (LTSS) help individuals perform daily activities in their home, such as bathing, dressing, preparing meals, and administering medications. The program aimed 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 has been developed to improve and enhance medical care access and coordination, as well as create a person-driven LTSS system, in which people have a full array of quality services and supports that foster independence, health, and quality of life. On January 1, 2018, the program began the first phase with enrollment of participants in one of the five geographic HealthChoices zones. This zone (Southwest) was comprised of 14 counties, including Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland. CHC expansion is planned for one additional zone in 2019 (Southeast) and three additional zones in 2020 (Lehigh/Capital, Northwest, and Northeast). The PA DHS Office of Long-Term Living (OLTL) contracted with IPRO as its external quality review organization (EQRO) to conduct the 2018 EQRs for CHC-MCOs and to prepare the technical reports, as required and subsequently described in terms of the overview and objectives of this report introduction. The CHC-MCOs that were participating in CHC as of December 2018 were:

CHC-MCOs

- AmeriHealth Caritas Pennsylvania (affiliated with Keystone First; AHC),
- Pennsylvania Health & Wellness (PHW), and
- University of Pittsburgh Medical Center Health Plan (UPMC).

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 are reviewed to determine MCO compliance with structure and operations standards established by the state (42 CFR §438.358), validation of performance improvement projects, and validation of MCO performance measures.

DHS contracted with IPRO as its EQRO to conduct the 2018 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; and
- Structure and Operations Standards Reviews conducted by DHS:
 - o For PH-MCOs, the information is derived from the DHS's monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from the HealthChoices Agreement, and from the National Committee for Quality Assurance (NCQA™) accreditation results for each MCO.
 - o 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 Program Standards and Requirements (PS&R) and Readiness Assessment Instrument (RAI) are also used.
 - o For CHIP-MCOs, the information is derived from monitoring conducted by DHS's CHIP every three years. The categories that were reviewed by CHIP are subsequently categorized to be consistent with the subparts prescribed by the Balanced Budget Act regulations.
 - o For CHC-MCOs, prior to starting enrollment structure and operations standards were assessed in terms of readiness and ability to provide required services.

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
NA	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), not compliant (NC), partially compliant (P), or not determined (ND). Categories regarded as not applicable (NA) to the applicable DHS entity are indicated as such. Each category as a whole was then assigned a compliance status value of C, NC, P, 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: Compliance with Structure and Operations Standards

This section of the EQR report presents a review by IPRO of the PH-, BH-, CHIP-, and CHC-MCOs with regard to compliance with structure and operations standards.

The format for this section of the report was developed to be consistent with the subparts prescribed by the BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol*. Under each subpart heading are the individual regulatory categories appropriate to those headings. For PH- and BH-MCOs, IPRO's findings are presented in a manner consistent with the three BBA regulations subparts, as explained in the *Protocol*, namely, Subpart C: Enrollee Rights and Protections; Subpart D: Quality Assessment And Performance Improvement (including access, structure and operation, and measurement and improvement standards); and Subpart F: Federal and State Grievance System Standards.

Evaluation of PH-MCO Compliance

For the PH Medicaid MCOs, the information for the Compliance with Standards section of the report is derived from the OMAP's monitoring of the MCOs against the SMART standards, from the HealthChoices Agreement, and from 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. 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 Agreements. 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 126 unique SMART Items were identified that were relevant to evaluation of PH-MCO compliance with the BBA regulations. These Items vary in review periodicity from annually, semiannually, quarterly, or monthly, to as needed. The SMART Items from Review Year (RY) 2017, RY 2016, and RY 2015 provided the information necessary for this assessment.

To evaluate PH-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 enrollee rights are summarized under Enrollee Rights 438.100. 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 2017, results from reviews conducted within the two prior review years (RY 2016 and RY 2015) 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.

Evaluation of CHIP-MCO Compliance

Prior to the on-site monitoring visit performed at the MCO, documents are provided to CHIP by the MCO that address various areas of compliance. These documents include training materials, provider manuals, MCO organization charts, policies and procedures manuals, and geographical access maps. Additional documents reviewed prior to the on-site monitoring visit include Quality of Care of Medical Services, Provider Adequacy, Applications and Eligibility, Customer

Service, Marketing Outreach, Audits, and IT reports. These items assess the MCO's 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 CHIP MCOs.

Throughout the visit, 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.

IPRO's findings are presented in a manner consistent with the three BBA regulations subparts, as explained in the *Protocol* in Subpart C: Enrollee Rights and Protections; Subpart D: Quality Assessment and Performance Improvement (including access, structure, and operation and measurement and improvement standards); and Subpart H: Certifications and Program Integrity. Subpart D was not included in the CHIP monitoring findings. The items are presented as found in the monitoring reports provided by CHIP, with full item descriptions presented when available. As PA CHIP continues to move forward with alignment of the EQR provisions to the CHIP population, re-assessment of the review items and crosswalks may be warranted.

IPRO reviewed the most recent elements in the areas that CHIP monitors and created a crosswalk to pertinent BBA regulations. A total of 27 unique items were identified that were relevant to evaluation of CHIP-MCOs' compliance with the BBA regulations. These items vary in review periodicity from annually, semiannually, quarterly, or monthly, to as needed. The items from Review Year (RY) 2017, 2016, and 2015, as applicable, provide the information necessary for this assessment. Information necessary for the review is provided through an on-site review that is conducted by CHIP, Quality Assurance Division. Throughout the duration of this on-site review, each area highlighted above is reviewed and a rating scale is utilized to determine compliance. The CHIP-MCO can be rated as not compliant, partially compliant, or compliant in each area, based on the findings of the audit. Following each rating scale, a comprehensive description of identified strengths and weaknesses is provided to the CHIP-MCO. If all items were compliant, the CHIP-MCO was evaluated as compliant. If some were compliant and some were not compliant, the CHIP-MCO was evaluated as partially compliant. If all items were not compliant, the CHIP-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, a value of not determined was assigned for that category.

Evaluation of BH-MCO Compliance

OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program; the mandatory managed care program that provides Medical Assistance recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH contractors while providing an oversight function of the BH-MCOs.

In some cases, the HealthChoices Oversight Entity is the HealthChoices Behavioral Health (HC BH) Contractor and, in other cases, multiple HC BH contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. Operational reviews are completed for each HealthChoices Oversight Entity. The Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH contractors, who, in turn, contract with a private sector BH-MCO. The HC BH contractor is responsible for its regulatory compliance with federal and state regulations and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the HC BH contractor's responsibility for the oversight of BH-MCOs' compliance.

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 2017, 2016, 2015). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2017. 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 Program Standards and Requirements (PS&R) are also used. In Calendar Year 2017, Cambria County moved from VBH to MBH. 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 2018 and entered into the PEPS Application as of February 2019 for RY 2017. 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's more rigorous monitoring criteria.

Because OMHSAS's 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 2017, RY 2016, and RY 2015 provided the information necessary for the 2018 assessment. Those standards not reviewed through the PEPS system in RY 2017 were evaluated on their performance based on RY 2016 and/or RY 2015 decisions, or other supporting documentation, if necessary. 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.

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision and evaluated the HC BH 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 Items linked to each provision. If all 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 (NA) 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. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Evaluation of CHC-MCO Compliance

During RY 2017, CHC-MCOs were assessed on structure and operations standards in terms of readiness: prior to the enrollment of CHC participants and the start date for each zone, the Department determines the CHC-MCO's ability to provide required services. CHC-MCOs must cooperate with all the readiness activities, including on-site visits by the Department. As part of determining readiness, the CHC-MCOs must test successfully their claims processing systems prior to implementation of CHC in a given zone. If readiness is not sufficiently demonstrated, the Department will not permit the enrollment of CHC participants; the Department may extend the time period for the readiness determinations, or not authorize the CHC-MCO operations.

Readiness to operate and commence enrollment of CHC participants was ascertained through on-site readiness reviews, which is a required methodology for standardized determinations on CHC-MCO capacity and capability. The Department conducted on-site readiness visits in August and September 2017. Information was collected using a formalized and standardized readiness review tool, which was adapted from an existing readiness review tool used for the HealthChoices readiness review process. Collected information was used to identify strengths and opportunities for improvement. The readiness review reports provided an evaluation of structural systems for CHC claims processing by zone. Additionally, the following operational domains were evaluated:

- organizational overview,
- participant services contact center,
- overview of the case management system,
- provider services,
- overview of the provider directory,
- provider dispute process,
- subcontracting and oversight, and
- service coordination.

To evaluate compliance of the CHC-MCOs' individual provisions, the readiness review tool used the domains listed above to ascertain readiness. The Department utilized an existing readiness review tool to ensure CHC-MCO compliance and readiness prior to CHC implementation. Findings on the structural systems and operational domains for each of the CHC-MCOs were provided to IPRO and included multiple reports for each CHC-MCO, including justifications and integrations using supplemental readiness documentation. IPRO reviewed the findings with orientation and support from the Department and confirmed determinations were in alignment with the readiness review documentation.

For subsequent years, BBA reporting will include findings from reviews of CHC-MCOs' ongoing operations and functioning structures for compliance with the standards, in accordance with BBA requirements. Monitoring standards will be grouped by provision to evaluate the CHC-MCOs' compliance statuses with each item, which will be assigned a value of compliant or not compliant; or, if an item is not evaluated for a particular CHC-MCO, an assigned value will be not determined. If all items are compliant, then the CHC-MCO will be evaluated as compliant; if some items are compliant and some are not compliant, then the CHC-MCO will be evaluated as partially compliant; and, if all items are not compliant, then the CHC-MCO will be evaluated as not compliant. The format for this section of the report will be consistent with the subparts prescribed by BBA regulations, in which regulatory requirements are grouped under subject headings that are consistent with the three subparts set out in the BBA regulations, and described in the protocols for monitoring the CHC-MCOs; the individual regulatory categories will be reported to correspond with each subpart heading. Presentation of these findings will be consistent with the three subparts in the BBA regulations explained in the protocol (i.e., Enrollee Rights and Protections; Quality Assessment and Performance Improvement [including access, structure and operation, and measurement and improvement standards]; and Federal and State Grievance System Standards). In addition to this analysis of CHC-MCO compliance monitoring, IPRO will review and evaluate the most recent NCQA accreditation

report for the MCOs. This format reflects the goal of the review, which is to gather sufficient foundation for IPRO’s required assessment of the compliance of the MCOs with BBA regulations as an element of the analysis of the CHC-MCOs’ strengths and weaknesses.

Subpart C: Enrollee Rights and Protections

The general purpose of the Subpart C regulations is to ensure that each MCO has written policies regarding enrollee rights and complies with applicable federal and state laws that pertain to enrollee rights and that the MCO ensures that the MCO’s staff and affiliated providers take into account those rights when furnishing services to enrollees (42 CFR 438.100 [a], [b]).

Table 1a: PH-MCO Compliance with Subpart C – Enrollee Rights and Protections Regulations

Subpart C: Enrollee Rights and Protection	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
Enrollee Rights	C	C	C	C	C	C	C	C	C	C
Provider-Enrollee Communications	C	C	C	C	C	C	C	C	C	C
Marketing Activities	C	C	C	C	C	C	C	C	C	C
Liability for Payment	C	C	C	C	C	C	C	C	C	C
Cost Sharing	C	C	C	C	C	C	C	C	C	C
Emergency Services: Coverage and Payment	C	C	C	C	C	C	C	C	C	C
Emergency and Post-stabilization Services	C	C	C	C	C	C	C	C	C	C
Solvency Standards	C	C	C	C	C	C	C	C	C	C

- All eight categories in Subpart C were compliant overall for PH MMC.
- All nine PH-MCOs were compliant for all categories in Subpart C.

Table 1b: CHIP-MCO Compliance with Subpart C – Enrollee Rights and Protections Regulations

Subpart C: Enrollee Rights and Protection	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	IBC	NEPA	UHC	UPMC	TOTAL CHIP MMC
Medical Services											
Covered Services	C	C	C	P	P	C	C	P	NA	C	P
Bright Futures	C	C	C	C	C	C	C	C	C	C	C
Case Management / Special Needs Unit	C	C	C	C	C	C	C	C	C	C	C
Quality Improvement Plans	C	C	C	C	C	C	C	C	NA	NA	C
PH-95	NA	C	C	NA	NA	C	NA	NA	C	C	C
Utilization Management	NA	C	C	NA	NA	C	NA	NA	C	C	C
Disease Management	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Provider Network											
Network Adequacy	C	C	C	C	C	C	C	C	NA	C	C
MCO Certification and Provider Credentialing	C	C	C	C	C	C	C	C	NA	NA	C
Enrollment Validation	C	NA	C	P	P	C	C	P	NA	NA	P
Communication	C	NA	NA	C	C	NA	C	C	NA	NA	C
Program Exceptions	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Application and Renewal											
Transfers In / Out of Their Enrollment	C	NA	NA	C	C	NA	C	C	NA	NA	C
Renewal Rates	C	NA	NA	C	C	C	C	C	NA	NA	C
Application Timelines	C	NA	NA	C	C	C	C	C	NA	NA	C
Quality of Care											
Provider Network and Adequacy	NA	C	C	NA	NA	NA	NA	NA	P	NA	P
Provider Credentialing	NA	C	C	NA	NA	NA	NA	NA	C	C	C

Subpart C: Enrollee Rights and Protection	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	IBC	NEPA	UHC	UPMC	TOTAL CHIP MMC
Appointment Standards	NA	C	C	NA	NA	C	NA	NA	C	C	C
Application Timeliness and Renewal Rates	NA	C	C	NA	NA	C	NA	NA	NA	C	C
Communication to Providers and Members	NA	C	C	NA	NA	C	NA	NA	NA	NA	C
Provider Enrollment	NA	C	C	NA	NA	C	NA	NA	C	C	C
Quality Activities	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Accomplishments	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C

- For all CHIP-MCOs that were scored, each CHIP-MCO was found to be compliant for the Bright Futures, Case Management / Special Needs Unit, Quality Improvement Plans, PH-95, Utilization Management, Disease Management, Network Adequacy, MCO Certification and Provider Credentialing, Communication, Program Exceptions, Transfers In / Out of Their Enrollment, Renewal Rates, Application Timelines, Provider Credentialing, Appointment Standards, Application Timeliness and Renewal Rates, Communication to Providers and Members, and Provider Enrollment.
- Highmark HMO, Highmark PPO, and NEPA were all partially compliant for Covered Services. UHC was partially compliant for Provider Network and Adequacy.
- Only one CHIP-MCO was scored under the Quality Activities and Accomplishments items, and this plan was found to be compliant for both items.

Table 1c: BH-MCO Compliance with Subpart C – Enrollee Rights and Protections Regulations

Subpart C: Enrollee Rights and Protection	CBH	CCBH	MBH	PerformCare	VBH	TOTAL BH MMC
Enrollee Rights	P	P	P	P	P	P
Provider-Enrollee Communications	C	C	C	C	C	C
Marketing Activities	NA	NA	NA	NA	NA	NA
Liability for Payment	C	C	C	C	C	C
Cost Sharing	C	C	C	C	C	C
Emergency and Post-stabilization Services	C	C	C	C	C	C
Solvency Standards	C	C	C	C	C	C

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

- All five BH-MCOs were partially compliant with Enrollee Rights.
- Information pertaining to Marketing Activities was considered not applicable (NA) as OMHSAS received a Center for Medicare and Medicaid Services (CMS) waiver on the Marketing Activities category for PA BH-MCOs. As a result of the CMS HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per county.
- All five BH-MCOs were compliant for the remaining categories in Subpart C.

Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this heading is to ensure that all services covered under the DHS’s Medicaid Managed Care Program are available and accessible to MCO enrollees (42 CFR 438.206 [a]).

Table 2a: PH-MCO Compliance with Subpart D – Quality Assessment and Performance Improvement Regulations

Subpart D: Quality Assessment and Performance Improvement	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
Access Standards										
Availability of Services (Access to Care)	C	P	P	P	C	C	P	C	C	P
Coordination and Continuity of Care	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
Structure and Operation Standards										
Provider Selection	C	C	C	C	C	C	C	C	C	C
Provider Discrimination Prohibited	C	C	C	C	C	C	C	C	C	C
Confidentiality	C	C	C	C	C	C	C	C	C	C
Enrollment and Disenrollment	C	C	C	C	C	C	C	C	C	C
Grievance Systems	C	C	C	C	C	C	C	C	C	C
Subcontractual Relationships and Delegation	C	C	C	C	C	C	C	C	C	C
Measurement and Improvement Standards										
Practice Guidelines	C	C	C	C	C	C	C	C	C	C
Health Information Systems	C	P	P	C	C	C	P	C	C	P

- Each PH-MCO was compliant for 9 of the 11 categories of Quality Assessment and Performance Improvement Regulations: Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Provider Discrimination Prohibited, Confidentiality, Enrollment and Disenrollment, Grievance Systems, Subcontractual Relationships and Delegation, and Practice Guidelines.
- Four MCOs (ACN, ACP, GEI, and KF) were partially compliant for Availability of Services (Access to Care). ACN, ACP, and KF were also partially compliant for Health Information Systems.

Table 2b: CHIP-MCO Compliance with Subpart D – Quality Assessment and Performance Improvement Regulations

Subpart D: Quality Assessment and Performance Improvement	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	IBC	NEPA	UHC	UPMC	TOTAL CHIP MMC
Customer Service											
CHIP Dedicated Customer Service Staff	C	C	C	C	C	C	C	C	NA	C	C
CHIP Information	C	NA	NA	C	C	NA	C	C	NA	NA	C
MCO’s General Website	C	C	C	P	P	C	P	P	P	C	P
Member Issues – Blue/Green Sheets	C	C	C	C	C	C	C	C	C	C	C
Application Input	NA	C	C	C	C	C	NA	C	NA	C	C
UFI Random Sample	NA	C	C	C	C	C	NA	C	NA	C	C
Marketing and Outreach											
Community Outreach	C	NA	NA	C	C	NA	C	C	NA	NA	C
Programmatic Change Requests	C	C	P	C	C	C	C	C	C	C	P
Quarterly Intended and Completed	NA	C	C	NA	NA	C	C	NA	C	NA	C
Call Center Demonstration	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Handbooks	NA	NA	NA	NA	NA	NA	NA	NA	P	NA	P
Staff Training											
New Hire Orientation	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Appeals and Grievances	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Provider Services	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Enrollment	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C

- For all CHIP-MCOs that were scored, each was found to be compliant for CHIP Dedicated Customer Service Staff, CHIP Information, Member Issues – Blue/Green Sheets, Application Input, UFI Random Sample, Community Outreach, Quarterly Intended and Completed, and Call Center Demonstration.
- Highmark HMO, Highmark PPO, IBC, NEPA, and UHC were all partially compliant for MCO’s General Website.
- Only UHC was scored under the Call Center Demonstration (compliant) and Handbooks (partially compliant). UHC was also the only CHIP-MCO scored under items within the Staff Training section, and UHC was found to be compliant for all sections.

Table 2c: BH-MCO Compliance with Subpart D – Quality Assessment and Performance Improvement Regulations

Subpart D: Quality Assessment and Performance Improvement	CBH	CCBH	MBH	PerformCare	VBH	TOTAL BH MMC
Access Standards						
Elements of State Quality Strategies	C	C	C	C	C	C
Availability of Services (Access to Care)	P	P	P	P	P	P
Coordination and Continuity of Care	NC	NC	NC	NC	P	P
Coverage and Authorization of Services	P	P	P	P	P	P
Structure and Operation Standards						
Provider Selection	P	C	C	C	C	P
Confidentiality	C	C	C	C	C	C
Subcontractual Relationships and Delegation	C	C	C	P	P	P
Measurement and Improvement Standards						
Practice Guidelines	P	P	P	P	P	P
Quality Assessment and Performance Improvement Program	P	P	P	C	P	P
Health Information Systems	C	C	C	C	C	C

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

- All five BH-MCOs were compliant for 3 of the 10 categories: Elements of State Quality Strategies, Confidentiality, and Health Information Systems. Across the other 7 categories, some or all of the BH-MCOs were partially compliant, therefore making BH MMC overall partially compliant for those categories. For 6 categories that were partially compliant for BH MMC, each category had multiple BH-MCOs that were partially compliant or not compliant.
- PerformCare was compliant with Quality Assessment and Performance Improvement Regulations. The other four BH-MCOs were partially compliant.
- CBH, CCBH, and MBH were compliant for Subcontractual Relationships and Delegation. The other two BH-MCOs were partially compliant.
- All five BH-MCOs were partially compliant for Availability of Services (Access to Care), Coverage and Authorization of Services, and Practice Guidelines.
- CBH, CCBH, MBH, and PerformCare were not compliant for Coordination and Continuity of Care. VBH was partially compliant.

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this heading is to ensure that enrollees have the ability to pursue grievances.

Table 3a: PH-MCO Compliance with Subpart F – Federal and State Grievance System Standards

Subpart F: Federal and State Grievance System Standards	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
General Requirements	C	C	C	C	C	C	C	C	C	C
Notice of Action	C	C	C	C	C	C	C	C	C	C
Handling of Grievances and Appeals	C	C	C	C	C	C	C	C	C	C
Resolution and Notification: Grievances and Appeals	C	C	C	C	C	C	C	C	C	C
Expedited Appeals Process/Resolution	C	C	C	C	C	C	C	C	C	C
Information to Providers & Subcontractors	C	C	C	C	C	C	C	C	C	C
Recordkeeping and Recording Requirements	C	C	C	C	C	C	C	C	C	C
Continuation of Benefits Pending Appeal and State Fair Hearings	C	C	C	C	C	C	C	C	C	C
Effectuation of Reversed Resolutions	C	C	C	C	C	C	C	C	C	C

- All nine PH-MCOs were compliant for all categories of Federal and State Grievance Standards.

Table 3b: BH-MCO Compliance with Subpart F – Federal and State Grievance System Standards

Subpart F: Federal and State Grievance System Standards	CBH	CCBH	MBH	PerformCare	VBH	TOTAL BH MMC
Statutory Basis and Definitions	P	P	P	P	P	P
General Requirements	P	P	P	P	P	P
Notice of Action	P	C	P	P	P	P
Handling of Grievances and Appeals	P	P	P	P	P	P
Resolution and Notification: Grievances and Appeals	P	P	P	P	P	P
Expedited Appeals Process/Resolution	P	P	P	P	P	P
Information to Providers & Subcontractors	C	C	P	P	P	P
Recordkeeping and Recording Requirements	C	C	C	C	C	C
Continuation of Benefits Pending Appeal and State Fair Hearings	P	P	P	P	P	P
Effectuation of Reversed Resolutions	P	P	P	P	P	P

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

- All five BH-MCOs were partially compliant with 9 of 10 categories of Subpart F: Federal and State Grievance System Standards.
- CCBH was compliant for Notice of Action. The other four BH-MCOs were partially compliant.
- CBH and CCBH were compliant for Information to Providers and Subcontractors. The other three BH-MCOs were partially compliant.
- All BH-MCOs were compliant for Recordkeeping and Recording Requirements.

Subpart H: Certification and Program Integrity (CHIP)

The general purpose of the regulations included under this heading is to ensure the promotion of program integrity through programs that prevent fraud and abuse through means of misspent program funds and to promote quality health care services for CHIP enrollees.

Table 4: CHIP-MCO Compliance with Subpart H – Certification and Program Integrity

Subpart H: Certification and Program Integrity	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	IBC	NEPA	UHC	UPMC	TOTAL CHIP MMC
Audits and Reports											
ERP Logs and Resolution	C	C	C	C	C	C	P	C	C	C	P
Fraud and Abuse	C	C	C	C	C	C	C	C	C	C	C
HIPAA Breaches	P	C	C	C	C	C	C	C	C	C	P
PERM	C	C	C	C	C	C	C	C	C	C	C
PPS Reporting	C	C	P	C	C	C	C	C	C	C	P
A-133	C	C	C	C	C	C	C	C	C	C	C
Provider Integrity Report (Potentially Precluded Providers)	C	NA	NA	C	C	NA	P	C	NA	NA	P
HEDIS/CAHPS	C	NA	NA	C	C	NA	C	C	C	NA	C
Information Technology Files and Reports											
TMSIS	C	NA	C	C	C	C	P	C	C	C	P
Provider Files	C	C	C	C	C	C	NC	C	C	C	P
Ad Hoc	NA	C	C	C	C	C	C	C	NA	NA	C
Testing	NA	C	C	C	C	C	NA	C	C	C	C
Application and Renewal Processing and Timeframes											
Standard Operating Procedures	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Application/Renewal Timeliness	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Application/Renewal Input	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C
Transfers	NA	NA	NA	NA	NA	NA	NA	NA	C	NA	C

- For all CHIP-MCOs that were scored, each CHIP-MCO was found to be compliant for Fraud and Abuse, PERM, A-133, HEDIS/CAHPS, Ad Hoc, and Testing.
- ABH was partially compliant for HIPAA Breaches, and GEI was partially compliant for PPS Reporting. IBC was partially compliant for three Items (ERP Logs and Resolution, Provider Integrity Report (Potentially Precluded Providers), and TMSIS), and was not compliant for one Item (Provider Files).
- Only UHC was scored under the Application and Renewal Processing and Timeframes section, and this MCO was found to be compliant for all Items.

Readiness Review (CHC)

The general purpose of the standards included under this heading is to evaluate compliance of the CHC-MCOs' individual provisions to ascertain readiness. OLTL utilized an existing readiness review tool to ensure CHC-MCO compliance and readiness prior to CHC implementation. Findings on the structural systems and operational domains for each of the CHC-MCOs were provided to IPRO, which included multiple reports for each CHC-MCO, including justifications and integrations using supplemental readiness documentation. IPRO reviewed the findings with orientation and support from OLTL, and confirmed determinations were in alignment with the readiness review documentation.

Table 5: CHC-MCO Readiness Review: Compliance with Structure and Operations Standards

CHC-MCO Readiness Review: Compliance with Structure and Operations Standards	AHC	PHW	UPMC	TOTAL CHC MMC
Structure and Operations Standards				
Organizational Overview	C	C	C	C
Participant Services Call Center	C	C	C	C
Case Management System	C	C	C	C
Provider Services	C	C	C	C
Provider Directory	C	C	C	C
Provider Dispute Process	C	C	C	C
Subcontracting and Oversight	C	C	C	C
Service Coordination	C	C	C	C

Note: Findings on the Structural Systems and Operational domains for each of the CHC-MCOs were provided to IPRO, which included multiple reports for each CHC-MCO, including justifications and integrations using supplemental readiness documentation. IPRO reviewed the findings with orientation and support from OLTL, and confirmed determinations were in alignment with the readiness review documentation.

- All three CHC-MCOs were compliant for all Structure and Operations Standards categories: Organizational Overview, Participant Services Call Center, Case Management System, Provider Services, Provider Directory, Provider Dispute Process, Subcontracting and Oversight, and Service Coordination. Therefore, CHC MMC was overall compliant for these categories, Structure and Operations Standards, and with Subpart D: Quality Assessment and Performance Improvement.
- At the time of this report, the NCQA accreditation status is in process (and the accreditation will be reported in next year's BBA report). In accordance with the contract, all three CHC-MCOs are subject to full review of the first requirements for NCQA accreditation; one CHC-MCO (UPMC) underwent the full review in 2017 and two CHC-MCOs (PHW and AHCW) are undergoing full reviews, expected to be completed by December 31, 2019. Additionally, OLTL requires that all CHC-MCOs have LTSS accreditation.

Section II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of PIPs for each Medicaid MCO.

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 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

The total points earned for each review element are weighted to determine the MCO's overall performance score for a PIP. The nine review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all seven 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. The evaluation of the sustained improvement area has one review element.

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%.

Table 6a indicates the PIP Review Element Scoring Weights utilized for the current PH and BH PIPs in progress. As discussed below, as part of the new EQR PIP cycle that was initiated for all CHIP-MCOs in 2017 and for all CHC-MCOs in 2018, IPRO adopted the LEAN methodology, including re-developed templates for submission and evaluation.

Table 6a: PIP Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic and Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4/5	Identified Study Population and Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8/9	Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	20%
Total Demonstrable Improvement Score		80%
10	Sustainability of Documented Improvement	20%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

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 2018 for 2017 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 new PIPs were initiated as part of this requirement. 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 new EQR PIP cycle that was initiated for all PH-MCOs in 2015, PH-MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: “Improving Access to Pediatric Preventive Dental Care” and “Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits.”

“Improving Access to Pediatric Preventive Dental Care” was selected because, on a number of dental measures, the aggregate HealthChoices rates have consistently fallen short of established benchmarks or have not improved across years. For one measure, the HEDIS Annual Dental Visit (ADV) measure, from HEDIS 2006 through HEDIS 2013, the Medicaid Managed Care (MMC) average was below the 50th percentile for three years. Further, CMS reporting of Federal Fiscal Year (FFY) 2011-2013 data from the CMS-416 indicate that while PA met its two-year goal for progress on preventive dental services, the percentage of PA children age 1-20 who received any preventive dental service for FFY 2013 (40.0%) was below the national rate of 46.0%. The Aim Statement for the topic is “Increase access to and utilization of routine dental care for pediatric Pennsylvania HealthChoices members.” Four common objectives for all PH-MCOs were selected:

1. Increase dental evaluations for children between the ages of 6 months and 5 years.
2. Increase preventive dental visits for all pediatric HealthChoices members.
3. Increase appropriate topical application of fluoride varnish by non-oral health professionals.
4. Increase the appropriate application of dental sealants for children ages 6-9 (CMS Core Measure) and 12-14 years.

For this PIP, OMAP is requiring all PH-MCOs to submit the following core measures on an annual basis:

- Adapted from CMS-416, the percentage of children ages 0-1 who received, in the last year:
 - any dental service,
 - a preventive dental service,
 - a dental diagnostic service,
 - any oral health service, or
 - any dental or oral health service;
- Total Eligibles Receiving Oral Health Services Provided by a Non-dentist Provider;
- Total Eligibles Receiving Preventive Dental Services; and
- The percentages of children, stratified by age (< 1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who received at least one topical application of fluoride.

Additionally, MCOs are encouraged to consider other performance measures, such as:

- Percentage of children with early childhood caries (ECC) who are disease free at one year,
- Percentage of children with dental caries (ages 1-8 years),
- Percentage of oral health patients that are caries free, and
- Percentage of all dental patients for whom the Phase I treatment plan is completed within a 12-month period.

“Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits” was selected as the result of a number of observations. 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 Healthcare Effectiveness Data and Information Set (HEDIS) and PA Performance Measures across multiple years have highlighted this topic as an area of concern to be addressed for improvement. The Aim Statement for the topic is “To reduce potentially avoidable ED visits and hospitalizations, including admissions that are avoidable initial admissions and readmissions that are potentially preventable.” Five common objectives for all PH-MCOs were selected:

1. Identify key drivers of avoidable hospitalizations, as specific to the MCO’s population (e.g., by specific diagnoses, procedures, comorbid conditions, and demographics that characterize high-risk subpopulations for the MCO).

2. Decrease avoidable initial admissions (e.g., admissions related to chronic or worsening conditions, or identified health disparities).
3. Decrease potentially preventable readmissions (e.g., readmissions related to diagnosis, procedure, transition of care, or case management).
4. Decrease avoidable ED visits (e.g., resulting from poor ambulatory management of chronic conditions including BH/SA conditions or use of the ED for non-urgent care).
5. Demonstrate improvement for a number of indicators related to avoidable hospitalizations and preventable readmissions, specifically for Individuals with Serious Persistent Mental Illness (SPMI).

For this PIP, OMAP is requiring all PH-MCOs to submit the following core measures on an annual basis:

MCO-developed Performance Measures

MCOs are required to develop their own indicators tailored to their specific PIP (i.e., customized to the key drivers of avoidable hospitalizations identified by each MCO for its specific population).

DHS-defined Performance Measures

- Ambulatory Care (AMB): ED Utilization. The target goal is 72 per 1,000 member months.
- Inpatient Utilization—General Hospital/Acute Care (IPU): Total Discharges. The target goal is 8.2 per 1,000 months.
- Reducing Potentially Preventable Readmissions (RPR). The target for the indicator is 8.5. This measure replaced the originally designated measure – Plan All-Cause Readmissions (PCR): 30-day Inpatient Readmission.
- Each of the five BH-PH Integrated Care Plan (ICP) Program measures:
 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia,
 - Emergency Room Utilization for Individuals with Serious Persistent Mental Illness (SPMI),
 - Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI), and
 - Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI).

The PIPs extend from January 2015 through December 2018, with research beginning in 2015, initial PIP proposals developed and submitted in first quarter 2016, and a final report due in June 2019. The non-intervention baseline period is January 2015 to December 2015. Following the formal PIP proposal, the timeline defined for the PIPs includes required interim reports in July 2016, June 2017, and June 2018, as well as a final report in June 2019. Based on validation findings in 2016, the timeline has undergone adjustments.

The 2018 EQR is the 15th year to include validation of PIPs. For each PIP, all PH-MCOs share 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.

All PH-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.

To encourage 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 6b and 6c** summarize PIP compliance assessments across MCOs.

Table 6b: PH-MCO PIP Review Score – Improving Access to Pediatric Preventive Dental Care

Project 1 - Improving Access to Pediatric Preventive Dental Care	ABH	ACN-ACP	GEI	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic and Topic Relevance	C	C	C	C	C	C	C	C	C
2. Study Question (Aim Statement)	C	P	NC	C	P	P	C	C	P
3. Study Variables (Performance Indicators)	C	P	P	C	C	P	C	C	P
4/5. Identified Study Population and Sampling Methods	C	P	P	C	C	P	C	C	P
6. Data Collection Procedures	C	P	C	C	C	C	C	C	P
7. Improvement Strategies (Interventions)	P	P	C	C	P	P	C	C	P
8/9. Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	C	NC	P	P	P	P	C	C	P
10. Sustainability of Documented Improvement	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 6c: 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	ACN-ACP	GEI	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic and Topic Relevance	C	C	C	C	C	C	P	C	P
2. Study Question (Aim Statement)	C	C	C	P	C	C	C	C	P
3. Study Variables (Performance Indicators)	P	P	P	P	C	C	C	C	P
4/5. Identified Study Population and Sampling Methods	C	C	C	P	C	C	C	C	P
6. Data Collection Procedures	C	P	P	C	C	C	C	C	P
7. Improvement Strategies (Interventions)	C	C	C	P	C	C	C	C	P
8/9. Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	P	P	NC	P	P	P	C	C	P
10. Sustainability of Documented Improvement	NA	NA	NA	NA	NA	NA	NA	NA	NA

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 2017 for 2018 activities. Under the applicable agreement with the 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. 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 new EQR PIP cycle that was initiated for all CHIP-MCOs in 2017, IPRO has adopted the LEAN methodology, following the CMS recommendation that Quality Improvement Organizations (QIOs) and other health care stakeholders embrace LEAN in order to promote continuous quality improvement in health care.

CHIP-MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: “Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years” and “Improving Blood Lead Screening Rate in Children 2 Years of Age.”

“Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years” was selected after review of the HEDIS Developmental Screening in the First Three Years measure, as well as a number of additional developmental measures. The performance of these measures across Pennsylvania CHIP contractors has been flat and, in some cases, has not improved across years. Available data indicate that fewer than half of Pennsylvania children from birth to age 3 enrolled in CHIP and Medicaid in 2014 were receiving recommended screenings. Taking into account that approximately 1 in 10 Pennsylvania children may experience a delay in one or more aspects of development, this topic was selected with the aim of all children at risk are reached. The Aim Statement for the topic is “By the end of 2020, the MCO aims to increase developmental screening rates for children ages one, two, and three years old.” Contractors are asked to create objectives that support this Aim Statement.

For this PIP, DHS CHIP is requiring all CHIP contractors to submit rates at the baseline, interim, and final measurement years (MYs) for “Developmental Screening in the First Three Years of Life.” Additionally, contractors are encouraged to consider other performance measures, such as:

- Proportion of children identified at risk for developmental, behavioral, and social delays who were referred to early intervention;
- Percentage of children and adolescents with access to primary care practitioners; and
- Percentage of children with well-child visits in the first 15 months of life.

“Improving Blood Lead Screening Rates in Children 2 Years of Age” was selected as the result of a number of observations. Despite an overall decrease over the last 30 years in children with elevated blood lead levels in the United States, children from low-income families in specific states, including Pennsylvania, have seen decreased rates of screening of blood lead levels. Current CHIP policy requires that all children ages one and two years old and all children ages three through six without a prior lead blood test have blood levels screened, consistent with current Department of Health and CDC standards. The average national lead screening rate in 2016 is 66.5%, while the Pennsylvania CHIP average is 53.2%. Despite an overall improvement in lead screening rates for Pennsylvania CHIP contractors over the past few years, rates by contractor and weighted average fall below the national average. In addition to lead screening rate, contractors are encouraged to consider these measures as optional initiatives:

- Percentage of home investigations where lead exposure risk hazards/factors are identified,
- Total number of children successfully identified with elevated blood lead levels,
- Percentage of the population under the age of five suffering from elevated blood lead levels, or

- Percentage of individuals employed in the agriculture, forestry, mining, and construction industries.

The PIPs extend from January 2017 through December 2020, with research beginning in 2017, initial PIP proposals developed and submitted in second quarter 2018, and a final report due in June 2021. The non-intervention baseline period is January 2017 to December 2017. Following the formal PIP proposal, the timeline defined for the PIPs includes required interim reports in June 2019 and June 2020, as well as a final report in June 2021.

The year 2018 is the 10th year to include validation of PIPs. 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, *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.

Under the LEAN methodology adopted for the new CHIP PIP cycle and utilizing the new LEAN templates developed for this process, IPRO's review evaluated each project against seven review elements:

- Element 1. Project Topic/Rationale
- Element 2. Aim
- Element 3. Methodology
- Element 4. Barrier Analysis
- Element 5. Robust Interventions
- Element 6. Results Table
- Element 7. Discussion and Validity of Reported Improvement

The first six elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement.

To encourage 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 6d and 6e** summarize PIP compliance assessments across MCOs.

Table 6d: CHIP-MCO PIP Review Score – Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years

Project 1 - Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	NEPA	IBC	UHC	UPMC	TOTAL CHIP MMC
1. Project Topic and Rationale	P	P	P	C	C	C	C	P	C	P	P
2. Aim Statement	P	P	P	C	C	P	C	NC	P	P	P
3. Methodology	C	C	P	C	C	C	C	P	C	C	P
4. Barrier Analysis	C	P	P	C	C	C	C	P	C	C	P
5. Robust Interventions	C	P	P	P	P	P	P	P	P	P	P
6. Results Table	P	P	P	P	P	P	P	C	P	P	P
7. Discussion	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 6e: CHIP-MCO PIP Review Score – Improving Blood Lead Screening Rates in Children 2 Years of Age

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

BH-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH-MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, HC BH contractors, along with the responsible subcontracted entities (i.e., BH-MCOs), are required to conduct a minimum of two focused studies per year. The HC BH contractors and BH-MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH-MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2018 for 2017 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH contractors in 2014. For this PIP cycle, OMHSAS selected the topic, “Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis” as the topic for this PIP. The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS) Follow-up After Hospitalization (FUH) metrics.

The Aim Statement for this PIP is “Successful transition from inpatient care to ambulatory care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis.” OMHSAS selected three common objectives for all BH-MCOs:

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

Additionally, OMHSAS requires all BH-MCOs to submit the following core performance measures on an annual basis:

- **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Mental Health Discharges)**
The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days without a substance abuse diagnosis during the initial stay.
- **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Substance Abuse Discharges)**
The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days with a substance abuse diagnosis (primary or secondary) during the initial stay.
- **Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
The percentage of members diagnosed with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is based on the HEDIS measure of the same name.
- **Components of Discharge Management Planning**
This measure is based on review of facility discharge management plans and assesses the following:
 - a. The percentage of discharge plans, including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses, and provider phone numbers.
 - b. The percentage of discharge plans, including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses, and provider phone numbers where at least one of the scheduled appointments occurred.

This PIP project extended from January 2014 through December 2018, with initial PIP proposals submitted in 2014 and a final report to be due in September 2019. In 2016, OMHSAS elected to add an additional intervention year to the PIP cycle to allow sufficient time for the demonstration of outcomes. The non-intervention baseline period was from January 2014 to December 2014. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. BH-MCOs were required to submit interim reports in the summers of 2016, 2017, and 2018. BH-MCOs will be required to submit a final report in September 2019. Since MY 2017 was the second remeasurement, BH-MCOs will not be required to submit MY 2018 performance indicator results in the final report. BH-MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a collaboration between the HC BH contractors and BH-MCOs. The BH-MCOs and each of their HC BH contractors are required to collaboratively develop a root cause/barrier analysis that identifies potential barriers at the BH-MCO level of analysis. Each of the barriers identified should include the contributing HC BH contract-level data and illustrate how HC BH contractor

knowledge of their high-risk populations contributes to the barriers within their specific service areas. Each BH-MCO will submit the single root cause/barrier analysis according to the PIP schedule.

This PIP was formally introduced to the BH-MCOs and HC BH contractors during a quality management directors meeting on June 4, 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the BH-MCOs and HC BH contractors, as needed.

The 2018 EQR is the 15th review to include validation of PIPs. With this PIP cycle, all BH-MCOs/HC BH contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, remeasurement, and sustained improvement. Direction was given to the BH-MCOs/HC BH contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. The BH-MCOs were expected to implement the interventions that were planned in 2014, to monitor the effectiveness of their interventions, and to improve their interventions based on their monitoring results.

The BH-MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with the Centers for Medicare & Medicaid Services (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.

In 2017, OMHSAS continued conducting quarterly PIP review calls with each BH-MCO. The purpose of these calls was to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for technical assistance as necessary. MCOs were 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, BH-MCOs were asked to submit only one PIP interim report in 2017, rather than two semiannual submissions.

The BH-MCOs submitted their Year 3 PIP Update document for review in August 2018. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. IPRO reviewed and scored the BH-MCO submissions for Demonstrable Improvement.

While study designs and implementation improved in many areas, several of the BH-MCOs continued to struggle with data collection, trending, and reporting. Only two of the five BH-MCOs scored as met on the Demonstrable Improvement requirements. Perhaps most notably, all five BH-MCOs were found deficient in their interpretation and validation of results. The reasons varied but centered on the lack of working hypotheses and of adequate intervention tracking measures that would enable the BH-MCOs to detect and then explain any significant changes in either the implementation of their interventions or ultimately in the performance indicators themselves. In some cases, the problem was related to underdeveloped designs, but in other cases was related to insufficient data collection, management, and/or documentation. These issues all had the effect of undermining the topic relevance of project activities. That said, BH-MCOs did continue to make improvements in their quarterly report-outs, even if those improvements were not reflected in their Annual Report. Finally, it should be noted that there was as much variation in performance among the plans as there were similarities, with BH-MCOs evincing different strengths and opportunities for improvement. **Table 6f** summarizes PIP compliance assessments across MCOs.

Table 6f: BH-MCO PIP Review Score – Successful Transition from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis

Successful transition from inpatient care to ambulatory care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis	CBH	CCBH	MBH	PerformCare	VBH	TOTAL BH MMC
1. Project Topic and Topic Relevance	P	P	P	P	P	P
2. Study Question (Aim Statement)	C	C	C	C	C	C
3. Study Variables (Performance Indicators)	P	C	C	C	P	P
4/5. Identified Study Population and Sampling Methods	C	C	C	C	C	P
6. Data Collection Procedures	P	C	C	P	P	P
7. Improvement Strategies (Interventions)	C	C	C	P	P	P
8/9. Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	P	P	P	P	P	P
10. Sustainability of Documented Improvement	NA	NA	NA	NA	NA	NA

CHC-MCO PIP Review

In accordance with current BBA regulations, IPRO will undertake validation of PIPs for the CHC-MCOs. For the purposes of the EQR, the CHC-MCOs are required to participate in studies selected by the DHS OLTL for proposal review and validation of methodology, and reported on in the 2018 BBA report. Two new PIPs were initiated as part of this requirement. Over the course of implementation of all PIPs, the CHC-MCOs must implement improvement actions and 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, IPRO has adopted the LEAN methodology, following the CMS recommendation that QIOs and other health care stakeholders embrace LEAN in order to promote continuous quality improvement in healthcare.

The CHC-MCOs are required to develop and implement PIPs to assess and improve outcomes of care rendered by the CHC-MCOs. PIP topics were discussed and selected in collaboration with the DHS OLTL and IPRO. For the current EQR PIP cycle, the CHC-MCOs were required to implement interventions and measure performance on two topics: Strengthening Care Coordination (clinical) and Transition of Care from the Nursing Facility to the Community (non-clinical). An evaluation is conducted for each PIP upon proposal submission, and then again for interim and final remeasurement, using a tool developed by IPRO and consistent with CMS EQR protocols for PIP validation. PIP proposals were submitted on September 15, 2018, ahead of PIP implementation on January 1, 2019, for the Southwest zone; eligible populations for both topics included the Nursing Facility Clinically Eligible (NFCE) participants. The Southeast zone and Phase III zones (Lehigh/Capital, Northeast, and Northwest) will be phased into the two PIP topics as they are integrated into the CHC program. After the first 18 months of implementation, the eligible population for both PIPs will also include Nursing Facility Ineligible (NFI) participants.

PIP activities occurring in 2018 included establishing PIP performance indicator goals, baseline rates, barrier analyses, and intervention development. During establishment of measurement parameters, multiple data sources were allowable, including: CHC-MCO pharmacies, service coordinator entities, copayments (i.e., after day 20), and traditional long-term care claims. Preliminary measurements were based on participants who were Medicaid-only CHC participants and/or aligned D-SNP CHC participants (at the time of submission of PIP proposals, CHC-MCOs' data were sourced from internal claims). For subsequent reporting, baseline rates will be recalculated (and integrated into the PIP) with improved access to data. Final baseline data will be included in the next year's

BBA report. The standards for demonstrable and sustainable improvement will be reported by the CHC-MCOs and evaluated by IPRO at the end of the current PIP cycle in 2021; therefore, this section will be reported in the subsequent BBA report.

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

All CHC-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.

Under the LEAN methodology adopted for the new CHC-PIP cycle and utilizing the new LEAN templates developed for this process, IPRO's review evaluated each project against seven review elements:

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

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. **Tables 6g** and **6h** summarize PIP compliance assessments across CHC-MCOs.

Table 6g: CHC-MCO PIP Proposal Review Score – Strengthening Care Coordination

Project 1 - Strengthening Care Coordination	AHC	PHW	UPMC	TOTAL CHC MMC
1. Project Topic and Rationale	P	P	P	P
2. Aim Statement	P	P	P	P
3. Methodology	C	C	P	C
4. Barrier Analysis	P	C	C	C
5. Robust Interventions	P	P	P	P
6. Results Table	NA	NA	NA	NA
7. Discussion	NA	NA	NA	NA
8. Sustainability	NA	NA	NA	NA

Table 6h: CHC-MCO PIP Proposal Review Score – Transitions of Care from the Nursing Facility to the Community

Project 1 - Transitions of Care from the Nursing Facility to the Community	AHC	PHW	UPMC	TOTAL CHC MMC
1. Project Topic and Rationale	C	P	C	C
2. Aim Statement	P	P	P	P
3. Methodology	P	C	C	C
4. Barrier Analysis	C	C	C	C
5. Robust Interventions	P	P	P	P
6. Results Table	NA	NA	NA	NA
7. Discussion	NA	NA	NA	NA
8. Sustainability	NA	NA	NA	NA

Section III: 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® 2018, 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 2018. The PH-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® 2018: Volume 2: Technical Specifications*. All the PH-MCO HEDIS rates are compiled and provided to DHS on an annual basis. **Table 7** represents the HEDIS performance for all nine PH-MCOs in 2018, as well as the PH MMC mean and the PH MMC weighted average.

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 2018 measures.

Table 7 is the full set of HEDIS 2018 measures reported to OMAP. The individual MCO 2018 EQR reports include a subset of these measures.

Table 7: PH-MCO HEDIS 2018 Measure Results

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
Effectiveness of Care												
Prevention and Screening												
Adult BMI Assessment (ABA)												
ABA: Rate	86.13%	90.51%	93.19%	89.54%	94.56%	93.40%	88.81%	91.97%	95.83%	91.55%	91.93%	▲
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)												
WCC: BMI Percentile Ages 3-11 years	69.20%	72.79%	84.94%	72.95%	83.40%	80.17%	82.33%	82.19%	75.86%	78.20%	78.65%	▲
WCC: BMI Percentile Ages 12-17 years	74.59%	75.54%	84.21%	64.07%	80.99%	77.52%	77.34%	83.54%	74.59%	76.93%	76.30%	▲
WCC: BMI Percentile Total	70.80%	73.72%	84.67%	69.34%	82.53%	79.25%	80.78%	82.73%	75.42%	77.69%	77.80%	▲
WCC: Counseling for Nutrition Ages 3-11 years	65.40%	75.00%	75.68%	64.75%	72.33%	82.64%	79.86%	79.76%	71.98%	74.16%	74.44%	▼
WCC: Counseling for Nutrition Ages 12-17 years	68.85%	84.17%	75.00%	59.28%	69.01%	79.07%	78.13%	74.39%	67.21%	72.79%	71.66%	▼
WCC: Counseling for Nutrition Total	66.42%	78.10%	75.43%	62.53%	71.14%	81.40%	79.32%	77.62%	70.34%	73.59%	73.42%	▼
WCC: Counseling for Physical Activity Ages 3-11 years	56.75%	64.34%	68.73%	57.38%	65.22%	61.98%	71.38%	69.64%	66.81%	64.69%	65.38%	▲
WCC: Counseling for Physical Activity Ages 12-17 years	65.57%	75.54%	73.03%	57.49%	69.01%	72.09%	74.22%	75.00%	63.11%	69.45%	68.61%	▼
WCC: Counseling for Physical Activity Ages Total	59.37%	68.13%	70.32%	57.42%	66.58%	65.50%	72.26%	71.78%	65.54%	66.32%	66.51%	▲
Childhood Immunization Status (CIS)												
CIS: DtaP/DT	75.91%	72.51%	78.83%	75.18%	80.78%	83.70%	82.73%	77.86%	77.86%	78.37%	79.16%	▼

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
CIS: IPV	86.13%	91.24%	93.92%	90.75%	93.43%	94.40%	93.19%	91.48%	90.27%	91.65%	91.79%	▼
CIS: MMR	87.35%	86.62%	90.75%	89.54%	88.81%	93.67%	93.19%	91.00%	88.56%	89.94%	90.49%	▼
CIS: HiB	87.59%	89.78%	88.81%	87.10%	90.02%	93.67%	92.21%	89.54%	90.02%	89.86%	90.19%	▼
CIS: Hepatitis B	86.62%	93.19%	94.89%	92.70%	92.46%	95.13%	93.92%	93.19%	93.19%	92.81%	93.08%	▲
CIS: VZV	87.10%	88.32%	90.02%	88.81%	90.27%	94.16%	91.97%	91.24%	90.27%	90.24%	90.64%	▼
CIS: Pneumococcal Conjugate	77.37%	80.29%	80.29%	77.62%	82.24%	85.16%	81.75%	80.05%	80.05%	80.54%	80.69%	▼
CIS: Hepatitis A	81.02%	82.24%	84.91%	84.67%	80.78%	91.73%	89.29%	87.59%	84.43%	85.19%	86.00%	▼
CIS: Rotavirus	63.99%	70.80%	75.18%	72.26%	73.97%	75.91%	72.02%	70.32%	77.13%	72.40%	73.07%	▲
CIS: Influenza	52.55%	40.39%	53.04%	48.91%	46.96%	57.91%	60.83%	59.61%	51.34%	52.39%	53.94%	▲
CIS: Combination 2	70.56%	66.91%	76.89%	72.26%	76.16%	82.24%	79.56%	76.40%	74.45%	75.05%	76.07%	▼
CIS: Combination 3	68.13%	64.96%	74.21%	69.59%	73.24%	80.29%	77.37%	74.45%	71.53%	72.64%	73.62%	▼
CIS: Combination 4	64.72%	61.31%	72.51%	67.15%	67.64%	79.81%	75.43%	72.51%	69.34%	70.05%	71.30%	▼
CIS: Combination 5	54.50%	54.01%	63.75%	58.39%	62.29%	67.64%	64.23%	60.83%	64.96%	61.18%	62.41%	▲
CIS: Combination 6	44.77%	34.55%	45.99%	40.63%	42.82%	53.04%	54.99%	50.85%	45.01%	45.85%	47.44%	▲
CIS: Combination 7	52.31%	51.09%	63.26%	56.45%	57.66%	67.40%	63.50%	60.10%	63.50%	59.48%	60.96%	▲
CIS: Combination 8	43.55%	32.85%	45.99%	40.15%	40.88%	53.04%	54.50%	50.36%	44.04%	45.04%	46.75%	▲
CIS: Combination 9	37.71%	29.93%	40.88%	34.31%	39.66%	45.99%	47.69%	43.55%	41.36%	40.12%	41.60%	▲
CIS: Combination 10	36.50%	28.22%	40.88%	33.82%	37.96%	45.99%	47.45%	43.31%	40.63%	39.42%	41.04%	▲
Immunizations for Adolescents (IMA)												
IMA: Meningococcal	81.51%	86.37%	86.86%	90.51%	87.10%	89.29%	89.05%	85.40%	86.37%	86.94%	87.52%	▲
IMA: Tdap/Td	85.16%	88.81%	90.02%	90.75%	90.75%	90.51%	90.51%	89.54%	89.05%	89.46%	89.77%	▲
IMA: Combination #1	79.08%	84.67%	85.89%	88.32%	86.37%	88.08%	86.62%	83.94%	85.64%	85.40%	85.94%	▲
Lead Screening in Children (LSC)												
LSC: Rate	77.62%	81.75%	75.43%	75.43%	81.75%	82.73%	77.62%	81.51%	86.86%	80.08%	80.31%	▲
Breast Cancer Screening (BCS)												
BCS: Rate	45.72%	58.04%	63.08%	54.53%	58.91%	63.29%	62.73%	50.88%	57.49%	57.19%	58.41%	▼
Cervical Cancer Screening (CCS)												
CCS: Rate	50.36%	59.12%	63.26%	56.45%	60.26%	69.13%	61.56%	57.66%	62.24%	60.01%	60.82%	▲
Chlamydia Screening in Women (CHL)												
CHL: Ages 16-20 years	51.78%	46.12%	53.12%	53.71%	47.18%	74.97%	67.39%	56.64%	47.68%	55.40%	56.91%	▲
CHL: Ages 21-24 years	62.95%	54.86%	57.32%	63.52%	56.17%	75.53%	73.30%	66.26%	58.88%	63.20%	64.75%	▲
CHL: Total Rate	57.55%	50.40%	55.02%	58.05%	51.22%	75.25%	70.04%	61.02%	53.01%	59.06%	60.56%	▲
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)												
NCS: Rate	0.91%	2.55%	0.82%	0.91%	2.22%	0.54%	0.42%	0.60%	0.92%	1.10%	0.91%	▼
Respiratory Conditions												

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
Appropriate Testing for Children with Pharyngitis (CWP)												
CWP: Rate	79.69%	77.36%	80.10%	81.24%	84.23%	81.97%	84.24%	83.59%	85.75%	82.02%	82.92%	▲
Appropriate Treatment for Children with Upper Respiratory Infection (URI)												
URI: Rate	91.53%	88.62%	90.31%	89.99%	93.59%	95.40%	95.44%	89.62%	87.72%	91.36%	91.14%	▲
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)												
AAB: Rate	38.48%	28.24%	29.74%	37.55%	39.19%	44.64%	35.89%	37.71%	35.46%	36.32%	36.41%	▲
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)												
SPR: Rate	25.34%	26.72%	33.33%	29.46%	30.54%	29.02%	25.35%	31.45%	32.72%	29.33%	29.59%	▼
Pharmacotherapy Management of COPD Exacerbation (PCE)												
PCE: Systemic Corticosteroid	83.19%	80.89%	81.04%	72.53%	79.26%	72.67%	77.21%	73.44%	69.78%	76.67%	74.94%	▲
PCE: Bronchodilator	82.15%	87.84%	88.44%	82.04%	85.90%	90.78%	92.53%	81.84%	79.08%	85.62%	85.19%	▲
Medication Management for People With Asthma (MMA)												
MMA: 50% Ages 5-11 years	55.85%	69.60%	71.55%	53.78%	65.91%	55.59%	63.19%	56.29%	63.93%	61.74%	61.41%	▼
MMA: 50% Ages 12-18 years	52.59%	68.50%	69.45%	56.94%	63.40%	55.47%	66.19%	57.28%	62.49%	61.37%	62.08%	▲
MMA: 50% Ages 19-50 years	66.60%	73.57%	75.77%	61.00%	70.98%	67.42%	68.60%	64.30%	70.97%	68.80%	68.51%	▲
MMA: 50% Ages 51-64 years	75.54%	86.62%	82.54%	75.23%	82.55%	81.48%	79.45%	67.29%	82.25%	79.22%	79.70%	▼
MMA: 50% Total	60.73%	73.12%	74.11%	59.97%	69.27%	63.71%	67.21%	59.80%	68.56%	66.28%	66.21%	▲
MMA: 75% Ages 5-11 years	31.21%	50.92%	49.95%	31.10%	42.53%	29.20%	40.92%	33.73%	37.92%	38.61%	38.06%	▲
MMA: 75% Ages 12-18 years	30.46%	49.61%	51.17%	34.27%	42.52%	30.18%	44.35%	35.29%	39.16%	39.67%	40.03%	▲
MMA: 75% Ages 19-50 years	41.04%	57.93%	57.18%	39.06%	49.19%	42.90%	49.86%	39.79%	47.38%	47.15%	47.03%	▲
MMA: 75% Ages 51-64 years	48.92%	73.24%	67.26%	56.06%	65.44%	63.08%	63.36%	50.47%	60.33%	60.91%	61.84%	▲
MMA: 75% Total	36.16%	56.30%	55.15%	38.02%	47.86%	39.43%	46.73%	37.37%	44.54%	44.62%	44.46%	▲
Asthma Medication Ratio (AMR)												
AMR: 5-11 years	71.35%	75.00%	77.13%	74.10%	80.45%	73.43%	66.50%	69.46%	79.41%	74.09%	72.11%	▼
AMR: 12-18 years	68.77%	64.56%	72.74%	68.50%	72.67%	65.68%	66.45%	63.94%	69.27%	68.06%	67.86%	▲
AMR: 19-50 years	57.49%	54.89%	62.04%	57.32%	61.50%	59.61%	55.96%	49.66%	57.90%	57.37%	57.75%	▲
AMR: 51-64 years	58.47%	62.22%	64.77%	62.25%	64.11%	64.75%	55.07%	52.60%	67.54%	61.31%	61.18%	▲
AMR: Total Rate	64.13%	62.12%	68.73%	64.54%	68.24%	65.44%	61.81%	60.14%	66.73%	64.65%	64.46%	▲
Cardiovascular Conditions												
Controlling High Blood Pressure (CBP)												
CBP: Total Rate	60.83%	68.13%	65.94%	52.31%	70.47%	69.68%	62.77%	65.69%	65.89%	64.63%	64.35%	▲
Persistence of Beta Blocker Treatment After a Heart Attack (PBH)												
PBH: Rate	83.67%	86.42%	91.45%	84.46%	84.92%	79.40%	88.75%	80.17%	85.29%	84.95%	84.97%	▼
Statin Therapy for Patients With Cardiovascular Disease (SPC)												

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
SPC: Received Statin Therapy - 21-75 years (Male)	81.14%	72.16%	76.23%	81.53%	83.51%	81.03%	72.50%	81.36%	80.65%	78.90%	79.19%	▼
SPC: Received Statin Therapy - 40-75 years (Female)	80.99%	68.33%	74.92%	79.72%	80.92%	79.20%	67.61%	77.12%	74.57%	75.93%	75.78%	▼
SPC: Received Statin Therapy - Total Rate	81.08%	70.57%	75.64%	80.72%	82.36%	80.17%	70.38%	79.57%	78.05%	77.62%	77.70%	▼
SPC: Statin Adherence 80% - 21-75 years (Male)	62.10%	74.46%	81.36%	67.57%	65.81%	68.37%	79.90%	62.04%	68.24%	69.98%	69.85%	▼
SPC: Statin Adherence 80% - 40-75 years (Female)	59.15%	75.61%	80.33%	66.09%	67.92%	69.50%	81.30%	63.33%	68.33%	70.18%	70.20%	▼
SPC: Statin Adherence 80% - Total Rate	60.91%	74.92%	80.90%	66.92%	66.74%	68.89%	80.49%	62.57%	68.28%	70.07%	70.00%	▼
Diabetes												
Comprehensive Diabetes Care (CDC)												
CDC: HbA1c Testing	83.24%	87.10%	86.52%	87.40%	86.13%	89.06%	86.24%	84.91%	89.54%	86.68%	87.23%	▼
CDC: HbA1c Poor Control (> 9.0%)	38.86%	36.04%	34.24%	39.87%	32.30%	33.13%	35.49%	37.12%	30.69%	35.30%	34.70%	▼
CDC: HbA1c Control (< 8.0%)	47.95%	52.12%	51.55%	45.61%	55.47%	55.31%	54.39%	52.47%	55.14%	52.23%	52.87%	▲
CDC: HbA1c Control (< 7.0%)	32.60%	38.20%	36.74%	32.36%	38.76%	39.33%	38.93%	37.83%	40.63%	37.26%	37.83%	▲
CDC: Eye Exam	43.67%	58.83%	63.21%	55.82%	64.78%	62.66%	55.89%	57.14%	62.06%	58.23%	58.98%	▼
CDC: Medical Attention for Nephropathy	87.52%	89.93%	85.79%	90.59%	89.05%	91.56%	89.22%	88.52%	90.73%	89.21%	89.63%	▼
CDC: Blood Pressure Controlled (< 140/90 mm Hg)	60.61%	75.44%	72.13%	62.04%	82.12%	66.25%	67.00%	70.76%	72.34%	69.85%	69.20%	▲
Statin Therapy for Patients With Diabetes (SPD)												
SPD: Received Statin Therapy	63.86%	52.40%	53.10%	64.67%	64.76%	67.25%	50.56%	63.44%	61.84%	60.21%	60.27%	▼
SPD: Statin Adherence 80%	59.13%	75.00%	77.25%	61.57%	62.48%	64.96%	74.17%	59.55%	65.54%	66.63%	66.39%	
Musculoskeletal												
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)												
ART: Rate	77.50%	78.18%	85.10%	76.22%	79.33%	77.02%	70.43%	78.21%	75.83%	77.54%	76.55%	▲
Use of Imaging Studies for Low Back Pain (LBP)												
LBP: Rate	66.48%	67.18%	68.90%	69.30%	69.67%	76.66%	79.56%	72.89%	72.82%	71.49%	72.47%	▲
Behavioral Health												
Follow-up Care for Children Prescribed ADHD Medication (ADD)												
ADD: Initiation Phase	26.32%	29.19%	23.52%	50.24%	39.27%	53.98%	20.36%	55.38%	50.34%	38.73%	40.45%	▲
ADD: Continuation and Maintenance Phase	30.40%	35.29%	26.68%	57.87%	37.56%	61.92%	23.36%	63.96%	53.60%	43.41%	45.21%	▼
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)												
SSD: Rate	87.44%	89.35%	90.04%	88.14%	89.60%	89.31%	86.05%	86.69%	88.55%	88.35%	88.12%	▼
Diabetes Monitoring for People With Diabetes And Schizophrenia (SMD)												
SMD: Rate	68.91%	75.81%	70.55%	71.34%	80.31%	79.61%	76.03%	66.47%	76.25%	73.92%	74.85%	▼
Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia (SMC)												
SMC: Rate	NA	NA	NA	73.68%	NA	83.72%	82.61%	NA	67.57%	76.90%	78.07%	▲

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)												
SAA: Rate	54.57%	78.26%	69.72%	66.14%	71.77%	59.87%	70.16%	62.79%	70.39%	67.07%	66.56%	▼
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)												
APC: Ages 1-5 years	NA	NA	NA									
APC: Ages 6-11 years	1.84%	0.60%	0.70%	0.67%	1.09%	0.00%	0.23%	0.00%	1.60%	0.75%	0.85%	▼
APC: Ages 12-17 years	2.20%	1.87%	1.85%	2.07%	2.73%	0.84%	1.50%	0.79%	1.96%	1.76%	1.86%	▼
APC: Total Rate	2.06%	1.37%	1.37%	1.59%	2.13%	0.55%	1.10%	0.53%	1.83%	1.39%	1.50%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)												
APM: Ages 1-5 years	NA	NA	NA									
APM: Ages 6-11 years	66.15%	72.61%	68.77%	63.89%	76.01%	67.05%	54.26%	59.84%	59.93%	65.39%	64.36%	▲
APM: Ages 12-17 years	66.67%	67.40%	66.08%	64.24%	70.04%	60.30%	57.71%	60.88%	57.48%	63.42%	62.42%	▲
APM: Total Rate	66.62%	69.17%	67.10%	64.10%	72.24%	62.67%	56.68%	60.26%	58.29%	64.13%	63.08%	▲
Medication Management												
Annual Monitoring for Patients on Persistent Medications (MPM)												
MPM: ACE inhibitors or ARBs	85.33%	84.41%	88.01%	87.55%	88.03%	89.51%	86.63%	86.81%	86.72%	87.00%	87.27%	▼
MPM: Diuretics	84.67%	87.34%	88.22%	86.78%	89.11%	88.03%	85.15%	86.26%	86.48%	86.89%	86.73%	▼
MPM: Total Rate	85.07%	85.51%	88.10%	87.24%	88.44%	88.89%	86.00%	86.58%	86.63%	86.94%	87.06%	▲
Overuse/Appropriateness												
Use of Opioids at High Dosage (UOD)												
UOD: Rate per 1,000	77.14	60.05	73.14	73.68	68.30	90.51	114.09	97.26	72.57	80.75	84.20	NA
Use of Opioids from Multiple Providers (UOP)												
UOP: per 1,000 receiving prescription opioids (4 or more prescribers)	194.68	184.29	211.63	241.46	179.26	174.87	184.07	177.10	53.13	177.83	163.52	▼
UOP: per 1,000 receiving prescription opioids (4 or more pharmacies)	68.23	117.45	56.01	59.27	42.84	57.40	76.54	24.97	224.32	80.78	96.11	▼
UOP: per 1,000 receiving prescription opioids (4 or more prescribers & pharmacies)	31.01	45.56	29.77	34.25	20.84	30.24	38.14	12.48	28.36	30.07	30.40	▼
Access/Availability of Care												
Adults' Access to Preventive/Ambulatory Health Services (AAP)												
AAP: Ages 20 - 44 years	65.92%	82.30%	83.16%	82.28%	83.28%	75.26%	76.61%	71.73%	81.01%	77.95%	77.84%	▼
AAP: Ages 45 - 64 years	73.49%	87.06%	90.00%	89.24%	88.99%	86.98%	86.47%	79.70%	87.88%	85.53%	86.09%	▼
AAP: Ages 65 years and older	69.59%	88.17%	88.42%	88.04%	88.22%	84.53%	82.91%	74.60%	85.15%	83.29%	82.98%	▼
AAP: Total Rate	68.27%	83.96%	85.52%	84.64%	85.27%	79.57%	80.15%	74.28%	83.46%	80.57%	80.70%	▼
Children and Adolescents' Access to Primary Care Practitioners (CAP)												
CAP: Ages 12 - 24 months	94.64%	95.66%	92.95%	96.96%	97.24%	95.63%	96.18%	94.65%	97.37%	95.70%	95.98%	▼
CAP: Ages 25 months - 6 years	86.40%	87.27%	84.64%	89.26%	89.70%	88.13%	88.18%	87.40%	90.69%	87.96%	88.36%	▼

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
CAP: Ages 7 - 11 years	90.74%	90.37%	89.69%	93.34%	94.28%	92.60%	93.57%	91.30%	93.23%	92.12%	92.60%	▲
CAP: Ages 12 - 19 years	89.49%	90.00%	88.98%	92.03%	93.37%	90.27%	92.67%	91.11%	91.58%	91.06%	91.46%	▲
Annual Dental Visits (ADV)												
ADV: Ages 2 - 3 years	43.20%	42.84%	49.17%	54.59%	39.80%	61.67%	58.53%	46.14%	42.48%	48.71%	50.21%	▲
ADV: Ages 4 - 6 years	66.31%	71.69%	71.95%	72.42%	66.32%	74.61%	77.05%	66.63%	66.07%	70.34%	70.81%	▲
ADV: Ages 7 - 10 years	66.87%	73.41%	73.20%	70.36%	67.54%	73.97%	76.06%	67.19%	66.22%	70.54%	70.75%	▲
ADV: Ages 11 - 14 years	62.71%	69.20%	70.22%	65.56%	61.14%	69.51%	73.41%	62.80%	61.91%	66.27%	66.55%	▲
ADV: Ages 15 - 18 years	52.16%	60.67%	62.65%	58.30%	53.43%	59.47%	64.95%	54.39%	56.02%	58.01%	58.45%	▲
ADV: Ages 19 - 20 years	35.34%	48.63%	47.74%	43.89%	38.66%	42.26%	46.10%	37.43%	40.86%	42.32%	42.18%	▲
ADV: Total Rate	57.88%	64.30%	65.90%	63.70%	57.85%	66.51%	69.35%	58.81%	58.58%	62.54%	63.00%	▲
Prenatal and Postpartum Care (PPC)												
PPC: Timeliness of Prenatal Care	82.00%	85.40%	90.02%	81.51%	86.62%	89.29%	84.91%	84.43%	91.24%	86.16%	86.56%	▼
PPC: Postpartum Care	58.15%	65.94%	67.88%	66.18%	70.32%	74.45%	64.96%	63.26%	71.78%	66.99%	67.71%	▼
Utilization and Risk Adjusted Utilization												
Utilization												
Well-Child Visits in the First 15 Months of Life (W15)												
W15: 0 Visits	0.97%	0.97%	0.73%	0.73%	1.17%	2.26%	1.70%	1.46%	0.90%	1.21%	1.26%	▲
W15: 1 Visit	0.73%	0.97%	0.24%	1.22%	1.17%	1.69%	0.24%	0.73%	0.90%	0.88%	0.86%	▼
W15: 2 Visits	2.68%	0.73%	3.16%	3.16%	2.34%	3.67%	0.97%	1.95%	2.09%	2.31%	2.31%	▼
W15: 3 Visits	4.87%	1.46%	3.89%	4.38%	4.09%	4.52%	4.87%	4.14%	3.88%	4.01%	4.24%	▲
W15: 4 Visits	6.33%	6.08%	6.57%	8.52%	5.56%	9.60%	7.30%	5.35%	9.25%	7.17%	7.61%	▼
W15: 5 Visits	18.73%	14.36%	12.90%	13.63%	10.82%	9.89%	15.82%	11.92%	14.93%	13.66%	13.83%	▼
W15: ≥ 6 Visits	65.69%	75.43%	72.51%	68.37%	74.85%	68.36%	69.10%	74.45%	68.06%	70.76%	69.90%	▲
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)												
W34: Rate	72.99%	74.70%	82.00%	76.40%	79.86%	82.59%	75.18%	77.13%	77.70%	77.62%	77.58%	▲
Adolescent Well-Care Visits (AWC)												
AWC: Rate	47.93%	65.21%	66.18%	61.56%	60.69%	65.21%	63.99%	62.29%	61.46%	61.61%	61.98%	▲
Frequency of Selected Procedures (FSP)												
FSP: Bariatric Weight Loss Surgery F Ages 0-19 Procs/1,000 MM	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
FSP: Bariatric Weight Loss Surgery F Ages 20-44 Procs/1,000 MM	0.05	0.09	0.20	0.09	0.11	0.09	0.07	0.07	0.09	0.10		
FSP: Bariatric Weight Loss Surgery F Ages 45-64 Procs/1,000 MM	0.05	0.11	0.17	0.10	0.10	0.13	0.09	0.06	0.10	0.10		
FSP: Bariatric Weight Loss Surgery M Ages 0-19 Procs/1,000 MM	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
FSP: Bariatric Weight Loss Surgery M Ages 20-44 Procs/1,000 MM	0.02	0.04	0.08	0.01	0.02	0.03	0.02	0.02	0.04	0.03		
FSP: Bariatric Weight Loss Surgery M Ages 45-64 Procs/1,000 MM	0.02	0.01	0.06	0.01	0.02	0.02	0.03	0.03	0.03	0.03		
FSP: Tonsillectomy MF Ages 0-9 Procs/1,000 MM	0.59	0.74	0.88	0.63	0.73	0.66	0.53	0.54	0.76	0.67		
FSP: Tonsillectomy MF Ages 10-19 Procs/1,000 MM	0.27	0.38	0.39	0.30	0.28	0.19	0.20	0.20	0.37	0.29		
FSP: Hysterectomy Abdominal F Ages 15-44 Procs/1,000 MM	0.08	0.09	0.11	0.08	0.12	0.09	0.09	0.05	0.09	0.09		
FSP: Hysterectomy Abdominal F Ages 45-64 Procs/1,000 MM	0.27	0.29	0.23	0.20	0.27	0.23	0.27	0.24	0.19	0.24		
FSP: Hysterectomy Vaginal F Ages 15-44 Procs/1,000 MM	0.12	0.14	0.16	0.12	0.10	0.05	0.06	0.05	0.15	0.10		
FSP: Hysterectomy Vaginal F Ages 45-64 Procs/1,000 MM	0.16	0.11	0.20	0.16	0.11	0.13	0.11	0.16	0.14	0.14		
FSP: Cholecystectomy, Open M Ages 30-64 Procs/1,000 MM	0.02	0.01	0.04	0.02	0.04	0.05	0.02	0.01	0.03	0.03		
FSP: Cholecystectomy, Open F Ages 15-44 Procs/1,000 MM	0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01		
FSP: Cholecystectomy Open F Ages 45-64 Procs/1,000 MM	0.07	0.04	0.02	0.02	0.03	0.03	0.04	0.01	0.03	0.03		
FSP: Cholecystectomy Closed M Ages 30-64 Procs/1,000 MM	0.19	0.27	0.25	0.30	0.32	0.16	0.17	0.20	0.36	0.25		
FSP: Cholecystectomy Closed F Ages 15-44 Procs/1,000 MM	0.60	0.94	0.66	0.63	0.76	0.39	0.39	0.44	0.74	0.62		
FSP: Cholecystectomy Closed F Ages 45-64 Procs/1,000 MM	0.47	0.74	0.71	0.64	0.69	0.35	0.36	0.45	0.63	0.56		
FSP: Back Surgery M Ages 20-44 Procs/1,000 MM	0.16	0.27	0.20	0.20	0.33	0.11	0.12	0.14	0.28	0.20		
FSP: Back Surgery F Ages 20-44 Procs/1,000 MM	0.14	0.18	0.21	0.19	0.26	0.08	0.10	0.15	0.26	0.17		
FSP: Back Surgery M Ages 45-64 Procs/1,000 MM	0.44	0.81	0.74	0.75	0.79	0.33	0.44	0.51	0.80	0.62		
FSP: Back Surgery F Ages 45-64 Procs/1,000 MM	0.39	0.56	0.63	0.71	0.64	0.31	0.36	0.49	0.74	0.54		
FSP: Mastectomy F Ages 15-44 Procs/1,000 MM	0.02	0.05	0.04	0.03	0.03	0.03	0.05	0.02	0.03	0.03		
FSP: Mastectomy F Ages 45-64 Procs/1,000 MM	0.11	0.09	0.18	0.12	0.12	0.12	0.12	0.15	0.11	0.12		
FSP: Lumpectomy F Ages 15-44 Procs/1,000 MM	0.10	0.12	0.08	0.11	0.12	0.15	0.14	0.09	0.09	0.11		
FSP: Lumpectomy F Ages 45-64 Procs/1,000 MM	0.34	0.38	0.32	0.35	0.24	0.44	0.44	0.32	0.29	0.35		
Ambulatory Care: Total (AMBA)												
AMBA: Outpatient Visits/1,000 MM	275.26	396.63	398.19	371.66	407.67	305.40	314.79	317.53	373.77	351.21	346.52	▼
AMBA: Emergency Department Visits/1,000 MM	66.63	76.68	80.21	80.42	63.59	70.73	64.45	62.75	65.00	70.05	68.91	▼
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)												

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average
IPIA: Total Discharges/1,000 MM	5.76	7.14	7.13	7.48	6.17	7.08	8.41	6.65	7.01	6.98	
IPIA: Medicine Discharges/1,000 MM	2.64	3.41	3.25	3.68	2.90	3.18	4.50	3.32	3.03	3.32	
IPIA: Surgery Discharges/1,000 MM	1.46	1.53	1.59	2.03	1.41	1.80	1.97	1.54	2.06	1.71	
IPIA: Maternity Discharges/1,000 MM	2.25	3.02	3.24	2.49	2.53	2.85	2.73	2.43	2.59	2.68	
Antibiotic Utilization: Total (ABXA)											
ABXA: Total # of Antibiotic Prescriptions M&F	157,408	102,248	168,821	253,967	214,065	179,389	336,281	170,794	446,946	225,547	
ABXA: Average # of Antibiotic Prescriptions PMPY M&F	0.86	1.31	0.99	0.94	1.17	0.72	0.87	0.78	1.08	0.97	
ABXA: Total Days Supplied for all Antibiotic Prescriptions M&F	1,344,987	940,519	1,538,218	2,373,989	2,048,791	1,605,530	3,065,627	1,633,223	4,356,739	2,100,847	
ABXA: Average # Days Supplied per Antibiotic Prescription M&F	8.54	9.20	9.11	9.35	9.57	8.95	9.12	9.56	9.75	9.24	
ABXA: Total # of Prescriptions for Antibiotics of Concern M&F	62,736	43,582	62,545	95,011	91,762	63,589	120,098	63,563	180,134	87,002	
ABXA: Average # of Prescriptions for Antibiotics of Concern M&F	0.34	0.56	0.37	0.35	0.50	0.26	0.31	0.29	0.43	0.38	
ABXA: Percent Antibiotics of Concern of all Antibiotic Prescriptions	39.86%	42.62%	37.05%	37.41%	42.87%	35.45%	35.71%	37.22%	40.30%	38.72%	
Standardized Healthcare-Associated Infection Ratio (HAI)											
HAI-1: Plan-weighted SIR (CLABSI)	0.47	0.53	0.59	0.69	0.73	0.85	0.62	0.70	0.57	0.64	
HAI-1: Central line-associated bloodstream infections (CLABSI) - high SIR	0.18	0.14	0.07	0.21	0.20	0.52	0.27	0.31	0.22	0.23	
HAI-1: Central line-associated bloodstream infections (CLABSI) - moderate SIR	0.02	0.02	0.05	0.10	0.05	0.11	0.05	0.09	0.51	0.11	
HAI-1: Central line-associated bloodstream infections (CLABSI) - low SIR	0.36	0.60	0.72	0.59	0.59	0.26	0.40	0.46	0.10	0.45	
HAI-1: Central line-associated bloodstream infections (CLABSI) - unavailable SIR	0.44	0.24	0.16	0.10	0.15	0.12	0.28	0.15	0.18	0.20	
HAI-2: Plan-weighted SIR (CAUTI)	0.51	0.64	0.77	0.77	0.67	0.88	0.76	0.78	0.65	0.72	
HAI-2: Catheter-associated urinary tract infections (CAUTI) - high SIR	0.20	0.22	0.31	0.24	0.17	0.56	0.35	0.35	0.05	0.27	
HAI-2: Catheter-associated urinary tract infections (CAUTI) - moderate SIR	0.08	0.18	0.11	0.13	0.25	0.04	0.10	0.11	0.78	0.20	
HAI-2: Catheter-associated urinary tract infections (CAUTI) - low SIR	0.31	0.41	0.43	0.55	0.50	0.29	0.28	0.43	0.02	0.36	
HAI-2: Catheter-associated urinary tract infections (CAUTI) - unavailable SIR	0.41	0.19	0.15	0.08	0.09	0.11	0.27	0.11	0.16	0.17	
HAI-5: Plan-weighted SIR (MRSA)	0.47	0.57	0.76	0.66	0.44	0.60	0.50	0.64	0.63	0.58	

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average		
HAI-5: Methicillin-resistant staphylococcus aureus (MRSA) blood lab-identified events - high SIR	0.17	0.21	0.18	0.25	0.12	0.12	0.23	0.23	0.07	0.18			
HAI-5: Methicillin-resistant staphylococcus aureus (MRSA) blood lab-identified events - moderate SIR	0.17	0.09	0.44	0.27	0.04	0.39	0.25	0.20	0.71	0.28			
HAI-5: Methicillin-resistant staphylococcus aureus (MRSA) blood lab-identified events - low SIR	0.20	0.46	0.23	0.35	0.68	0.36	0.21	0.40	0.02	0.32			
HAI-5: Methicillin-resistant staphylococcus aureus (MRSA) blood lab-identified events - unavailable SIR	0.46	0.24	0.15	0.13	0.15	0.13	0.31	0.17	0.21	0.22			
HAI-6: Plan-weighted SIR (CDIFF)	0.57	0.76	0.75	0.83	0.83	0.79	0.63	0.80	0.85	0.76			
HAI-6: Clostridium difficile laboratory-identified events (CDIFF) - high SIR	0.30	0.36	0.19	0.36	0.47	0.34	0.23	0.37	0.23	0.32			
HAI-6: Clostridium difficile laboratory-identified events (CDIFF) - moderate SIR	0.03	0.05	0.01	0.03	0.07	0.10	0.19	0.08	0.52	0.12			
HAI-6: Clostridium difficile laboratory-identified events (CDIFF) - low SIR	0.28	0.47	0.71	0.55	0.44	0.44	0.32	0.45	0.14	0.42			
HAI-6: Clostridium difficile laboratory-identified events (CDIFF) - unavailable SIR	0.39	0.11	0.10	0.06	0.02	0.11	0.27	0.10	0.11	0.14			
Risk Adjusted Utilization													
Plan All-Cause Readmissions (PCR)													
PCR: Count of Index Hospital Stays (IHS) - 1-3 Stays (Ages 18-44)	1,561	831	1,730	3,536	1,820	2,635	5,536	2,217	4,837				
PCR: Count of Index Hospital Stays (IHS) - 1-3 Stays (Ages 45-54)	953	618	1,254	2,325	1,244	2,022	3,638	1,411	3,338				
PCR: Count of Index Hospital Stays (IHS) - 1-3 Stays (Ages 55-64)	976	567	1,143	2,506	1,249	2,289	3,641	1,544	3,685				
PCR: Count of Index Hospital Stays (IHS) - 1-3 Stays (Ages Total)	3,490	2,016	4,127	8,367	4,313	6,946	12,815	5,172	11,860				
PCR: Count of Index Hospital Stays (IHS) - 4+ Stays (Ages 18-44)	135	51	198	829	230	408	1,619	320	566				
PCR: Count of Index Hospital Stays (IHS) - 4+ Stays (Ages 45-54)	152	55	208	488	159	359	958	268	479				
PCR: Count of Index Hospital Stays (IHS) - 4+ Stays (Ages 55-64)	107	98	163	419	148	294	893	277	482				
PCR: Count of Index Hospital Stays (IHS) - 4+ Stays (Ages Total)	394	204	569	1,736	537	1,061	3,470	865	1,527				
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 18-44)	1,696	882	1,928	4,365	2,050	3,043	7,155	2,537	5,403				

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 45-54)	1,105	673	1,462	2,813	1,403	2,381	4,596	1,679	3,817		
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 55-64)	1,083	665	1,306	2,925	1,397	2,583	4,534	1,821	4,167		
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages Total)	3,884	2,220	4,696	10,103	4,850	8,007	16,285	6,037	13,387		
PCR: Count of Expected 30-day Readmissions - 1-3 Stays (Ages 18-44)	215.73	116.42	229.74	515.90	254.62	384.71	760.09	289.10	328.92		
PCR: Count of Expected 30-day Readmissions - 1-3 Stays (Ages 45-54)	154.20	96.41	199.64	399.44	195.43	369.02	610.09	222.94	240.00		
PCR: Count of Expected 30-day Readmissions - 1-3 Stays (Ages 55-64)	157.72	98.71	190.20	470.63	219.07	452.31	651.74	277.15	275.27		
PCR: Count of Expected 30-day Readmissions - 1-3 Stays (Ages Total)	527.69	311.47	619.46	1,385.58	669.38	1,205.83	2,022.21	789.25	844.43		
PCR: Count of Expected 30-day Readmissions - 4+ Stays (Ages 18-44)	45.71	12.47	71.38	313.86	90.78	147.04	642.74	122.24	55.52		
PCR: Count of Expected 30-day Readmissions - 4+ Stays (Ages 45-54)	55.60	22.73	82.45	173.73	63.98	161.37	390.19	94.18	46.22		
PCR: Count of Expected 30-day Readmissions - 4+ Stays (Ages 55-64)	37.04	30.30	62.33	154.86	53.77	118.48	353.09	114.18	53.07		
PCR: Count of Expected 30-day Readmissions - 4+ Stays (Ages Total)	138.37	65.50	216.16	642.49	208.52	426.95	1,385.92	330.60	154.84		
PCR: Count of Expected 30-day Readmissions - Total Stays (Ages 18-44)	261.52	128.86	301.15	829.79	345.43	531.61	1,402.38	411.50	384.15		
PCR: Count of Expected 30-day Readmissions - Total Stays (Ages 45-54)	209.73	119.19	282.02	573.01	259.41	530.49	1,000.09	317.16	286.28		
PCR: Count of Expected 30-day Readmissions - Total Stays (Ages 55-64)	194.72	129.01	252.58	625.37	272.83	570.58	1,005.19	391.33	328.36		
PCR: Count of Expected 30-day Readmissions - Total Stays (Ages Total)	666.11	376.96	835.89	2,027.67	877.85	1,632.63	3,408.45	1,119.86	998.67		
PCR: Observed Readmission Rate - 1-3 Stays (Ages 18-44)	6.47%	5.29%	4.86%	7.07%	6.70%	5.05%	8.02%	5.77%	5.25%	6.05%	
PCR: Observed Readmission Rate - 1-3 Stays (Ages 45-54)	6.93%	6.47%	6.54%	9.33%	7.40%	4.40%	8.16%	7.16%	7.31%	7.08%	
PCR: Observed Readmission Rate - 1-3 Stays (Ages 55-64)	7.48%	8.64%	7.79%	11.17%	9.61%	6.20%	8.87%	9.39%	6.51%	8.41%	
PCR: Observed Readmission Rate - 1-3 Stays (Ages Total)	6.88%	6.60%	6.18%	8.93%	7.74%	5.24%	8.30%	7.23%	6.22%	7.04%	
PCR: Observed Readmission Rate - 4+ Stays (Ages 18-44)	40.74%	37.25%	45.45%	54.52%	52.61%	39.46%	56.39%	47.81%	40.64%	46.10%	

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
PCR: Observed Readmission Rate - 4+ Stays (Ages 45-54)	43.42%	40.00%	40.87%	42.83%	42.77%	39.83%	47.60%	47.01%	40.08%	42.71%		
PCR: Observed Readmission Rate - 4+ Stays (Ages 55-64)	32.71%	34.69%	43.56%	52.03%	43.92%	35.03%	47.14%	51.99%	44.40%	42.83%		
PCR: Observed Readmission Rate - 4+ Stays (Ages Total)	39.59%	36.76%	43.23%	50.63%	47.30%	38.36%	51.59%	48.90%	41.65%	44.22%		
PCR: Observed Readmission Rate - Total Stays (Ages 18-44)	9.20%	7.14%	9.02%	16.08%	11.85%	9.66%	18.97%	11.08%	8.96%	11.33%		
PCR: Observed Readmission Rate - Total Stays (Ages 45-54)	11.95%	9.21%	11.42%	15.14%	11.40%	9.74%	16.38%	13.52%	11.42%	12.24%		
PCR: Observed Readmission Rate - Total Stays (Ages 55-64)	9.97%	12.48%	12.25%	17.03%	13.24%	9.49%	16.41%	15.87%	10.90%	13.07%		
PCR: Observed Readmission Rate - Total Stays (Ages Total)	10.20%	9.37%	10.67%	16.09%	12.12%	9.63%	17.53%	13.20%	10.26%	12.12%		
PCR: Expected Readmission Rate - 1-3 Stays (Ages 18-44)	0.1382	0.1401	0.1328	0.1459	0.1399	0.1460	0.1373	0.1304	0.0680	0.1310		
PCR: Expected Readmission Rate - 1-3 Stays (Ages 45-54)	0.1618	0.1560	0.1592	0.1718	0.1571	0.1825	0.1677	0.1580	0.0719	0.1540		
PCR: Expected Readmission Rate - 1-3 Stays (Ages 55-64)	0.1616	0.1741	0.1664	0.1878	0.1754	0.1976	0.1790	0.1795	0.0747	0.1662		
PCR: Expected Readmission Rate - 1-3 Stays (Ages Total)	0.1512	0.1545	0.1501	0.1656	0.1552	0.1736	0.1578	0.1526	0.0712	0.1480		
PCR: Expected Readmission Rate - 4+ Stays (Ages 18-44)	0.3386	0.2445	0.3605	0.3786	0.3947	0.3604	0.3970	0.3820	0.0981	0.3283		
PCR: Expected Readmission Rate - 4+ Stays (Ages 45-54)	0.3658	0.4133	0.3964	0.3560	0.4024	0.4495	0.4073	0.3514	0.0965	0.3598		
PCR: Expected Readmission Rate - 4+ Stays (Ages 55-64)	0.3462	0.3092	0.3824	0.3696	0.3633	0.4030	0.3954	0.4122	0.1101	0.3435		
PCR: Expected Readmission Rate - 4+ Stays (Ages Total)	0.3512	0.3211	0.3799	0.3701	0.3883	0.4024	0.3994	0.3822	0.1014	0.3440		
PCR: Expected Readmission Rate - Total Stays (Ages 18-44)	0.1542	0.1461	0.1562	0.1901	0.1685	0.1747	0.1960	0.1622	0.0711	0.1577		
PCR: Expected Readmission Rate - Total Stays (Ages 45-54)	0.1898	0.1771	0.1929	0.2037	0.1849	0.2228	0.2176	0.1889	0.0750	0.1836		
PCR: Expected Readmission Rate - Total Stays (Ages 55-64)	0.1798	0.1940	0.1934	0.2138	0.1953	0.2209	0.2217	0.2149	0.0788	0.1903		
PCR: Expected Readmission Rate - Total Stays (Ages Total)	0.1715	0.1698	0.1780	0.2007	0.1810	0.2039	0.2093	0.1855	0.0746	0.1749		
PCR: Observed to Expected Readmission Ratio - 1-3 Stays (Ages Total)	0.45	0.43	0.41	0.54	0.50	0.30	0.53	0.47	0.87	0.50		

PH-MCO HEDIS Measure	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average
PCR: Observed to Expected Readmission Ratio - 4+ Stays (Ages Total)	1.13	1.14	1.14	1.37	1.22	0.95	1.29	1.28	4.11	1.51	
PCR: Observed to Expected Readmission Ratio - Total Stays (Ages Total)	0.59	0.55	0.60	0.80	0.67	0.47	0.84	0.71	1.38	0.73	
Health Plan Descriptive Information											
Board Certification (BCR)											
BCR: % of Family Medicine Board Certified	30.92%	91.16%	91.16%	46.37%	83.91%	83.89%	87.85%	72.40%	85.46%	74.79%	
BCR: % of Internal Medicine Board Certified	54.76%	84.68%	84.68%	72.47%	84.03%	80.43%	82.57%	76.65%	85.39%	78.41%	
BCR: % of Ob/Gyns Board Certified	54.31%	82.83%	82.83%	57.81%	83.23%	82.17%	81.69%	80.15%	81.80%	76.31%	
BCR: % of Pediatricians Board Certified	40.36%	88.63%	88.63%	56.03%	89.37%	86.29%	88.68%	82.61%	89.02%	78.85%	
BCR: % of Geriatricians Board Certified	43.60%	80.00%	80.00%	62.50%	78.33%	86.27%	86.21%	60.05%	83.12%	73.34%	
BCR: % of Other Physician Specialists Board Certified	54.84%	88.41%	88.41%	66.48%	85.49%	88.83%	87.87%	79.01%	86.29%	80.63%	

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

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

PA Performance Measure results are presented for each PH-MCO in **Table 8**, along with the PH MMC average and PH MMC weighted average, which takes into account the proportional relevance of each MCO.

Table 8: PH-MCO PA Performance Measure 2018 Results

PH-MCO PA Performance Measure	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years)											
Rate	61.09%	66.53%	67.97%	55.66%	63.82%	64.74%	68.67%	56.24%	55.57%	62.25%	62.50%
Cesarean Rate for Nulliparous Singleton Vertex											
Rate ¹	24.14%	24.18%	21.11%	22.05%	25.81%	23.15%	23.39%	20.04%	25.83%	23.30%	23.60%
Percent of Live Births weighing less than 2,500 grams (Positive)											
Rate ¹	10.17%	9.38%	9.46%	7.16%	10.43%	10.04%	10.52%	10.18%	10.21%	9.73%	9.89%
Elective Delivery (Adult Core Measure PC01-AD)											

PH-MCO PA Performance Measure	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Rate ¹	4.05%	15.50%	11.74%	3.27%	2.47%	1.51%	5.64%	4.48%	2.73%	5.71%	4.69%
Reducing Potentially Preventable Readmissions											
Rate ²	11.42%	6.55%	7.87%	9.60%	9.50%	11.63%	12.60%	10.93%	8.66%	9.86%	10.35%
Prenatal Screening for Smoking											
Rate 1 - Prenatal Screening for Smoking	73.39%	69.95%	76.92%	89.85%	66.26%	94.84%	90.86%	86.58%	96.54%	82.80%	82.82%
CHIPRA Rate 1 - Prenatal Screening for Smoking during one of the first two visits	73.13%	69.95%	76.43%	87.87%	65.52%	93.37%	90.86%	86.58%	96.05%	82.19%	82.21%
Rate 2 - Prenatal Screening for Environmental Tobacco Smoke Exposure	39.53%	36.21%	38.46%	52.97%	18.23%	72.73%	57.78%	47.63%	55.06%	46.51%	46.54%
Rate 3 - Prenatal Counseling for Smoking	74.75%	90.29%	92.59%	88.14%	81.11%	72.86%	90.16%	100.00%	85.27%	86.13%	86.06%
Rate 4 - Prenatal Counseling for Environmental Tobacco Smoke*	82.14%	73.77%	58.54%	78.08%	59.09%*	80.77%	70.73%	100.00%	87.80%	76.77%	78.54%
Rate 5 - Prenatal Smoking Cessation	8.08%	8.74%	11.11%	15.97%	7.78%	21.74%	13.33%	5.90%	9.30%	11.33%	9.95%
Perinatal Depression Screening											
Rate 1 – Prenatal Screen for Depression	47.29%	68.23%	71.22%	84.75%	45.07%	93.12%	83.70%	76.05%	82.72%	72.46%	72.50%
CHIPRA Rate 1 – Prenatal Screening for Depression during one of the first two visits	40.05%	60.59%	59.31%	78.29%	37.93%	84.77%	78.27%	69.47%	77.53%	65.14%	65.17%
Rate 2 – Prenatal Screening Positive for Depression	22.40%	20.94%	23.00%	21.65%	30.60%	15.57%	12.98%	21.45%	20.00%	20.95%	20.15%
Rate 3 - Prenatal Counseling for Depression	60.98%	74.14%	75.76%	61.97%	71.43%	84.75%	86.36%	79.03%	70.15%	73.84%	73.66%
Rate 4 – Postpartum Screening for Depression	49.65%	59.86%	66.99%	84.27%	74.83%	79.41%	60.83%	90.80%	97.30%	73.77%	73.36%
Rate 5 – Postpartum Screening Positive for Depression	19.72%	10.40%	15.12%	18.67%	17.26%	9.63%	13.17%	14.98%	18.75%	15.30%	15.25%
Rate 6 – Postpartum Counseling for Depression*	60.71%*	100.00%*	96.77%	76.19%*	84.62%*	96.15%*	96.30%*	88.24%*	92.59%*	87.95%*	87.29%
Maternity Risk Factor Assessment											
CHIPRA Rate 1 - Prenatal Screening for Alcohol use	67.70%	69.70%	72.46%	91.83%	46.80%	94.59%	89.63%	83.68%	95.06%	79.05%	79.07%
CHIPRA Rate 2 - Prenatal Screening for Illicit drug use	68.22%	69.21%	72.70%	95.79%	48.03%	93.86%	87.65%	82.37%	93.33%	79.02%	79.05%
CHIPRA Rate 3 - Prenatal Screening for Prescribed or over-the-counter drug use	73.13%	70.44%	73.70%	96.29%	67.73%	95.09%	89.14%	88.68%	97.78%	83.55%	83.57%
CHIPRA Rate 4 - Prenatal Screening for Intimate partner violence	45.74%	47.78%	50.62%	54.70%	24.38%	77.15%	73.33%	63.16%	65.93%	55.87%	55.87%
Behavioral Health Risk Assessment (BHRA-CH)											
CHIPRA Rate - Prenatal Screening for Behavioral Health Risk Assessment	30.75%	40.64%	40.45%	39.79%	10.84%	69.78%	61.48%	47.63%	57.04%	44.27%	44.34%

PH-MCO PA Performance Measure	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Follow-up for Care Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (include the BH data) (CHIPRA 21)											
Rate 1 – Initiation Phase	26.32%	29.19%	23.52%	39.27%	50.24%	53.98%	20.36%	55.38%	50.34%	38.73%	40.45%
Rate 2 – Continuation Phase	30.40%	35.29%	26.68%	37.56%	57.87%	61.92%	23.36%	63.96%	53.60%	43.41%	45.21%
Rate 1 – BH ED Enhanced Initiation Phase	27.67%	32.78%	24.19%	41.09%	50.56%	54.27%	21.05%	55.46%	51.03%	39.79%	41.20%
Rate 2 – BH ED Enhanced Continuation Phase	33.49%	40.50%	27.47%	42.67%	60.06%	67.89%	25.09%	66.29%	58.08%	46.84%	48.46%
Frequency of Ongoing Prenatal Care (FPC)											
Numerator 1: < 21%	4.51%	3.65%	3.89%	1.70%	2.92%	1.95%	5.35%	2.92%	0.97%	3.10%	3.09%
Numerator 2: 21–40%	3.26%	7.79%	3.89%	2.19%	2.68%	4.14%	7.79%	6.57%	2.92%	4.58%	4.58%
Numerator 3: 41–60%	8.27%	6.81%	9.98%	4.87%	7.54%	6.81%	13.63%	6.81%	5.11%	7.76%	7.76%
Numerator 4: 61–80%	15.79%	10.22%	12.17%	12.17%	13.87%	10.22%	13.14%	19.71%	18.49%	13.97%	13.97%
Numerator 5: ≥ 81%	68.17%	71.53%	70.07%	79.08%	72.99%	76.89%	60.10%	63.99%	72.51%	70.59%	70.60%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)											
SAA Rate: MCO Defined	54.47%	78.26%	69.72%	71.77%	66.14%	59.87%	70.16%	62.79%	70.39%	67.06%	66.55%
SAA Rate: BH ED Enhanced	59.71%	76.76%	69.61%	75.98%	68.74%	62.86%	70.20%	66.91%	74.35%	69.46%	69.00%
Adult Asthma Admission Rate (PQI 15)											
Asthma in Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months ³	5.00	4.65	7.39	3.83	7.03	7.75	13.84	6.18	5.37	6.78	7.32
Chronic Obstructive Pulmonary Disease Admission Rate (PQI 05)											
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months ³	46.84	55.39	66.97	271.80	101.90	71.02	101.24	79.15	68.36	95.85	94.49
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 65+ years) per 100,000 member months ³	10.73	118.20	79.49	193.14	73.15	32.60	59.47	16.32	38.97	69.12	55.45
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 40+ years) per 100,000 member months ³	46.12	56.16	67.23	270.78	101.42	70.04	100.13	77.70	68.03	95.29	93.74
Diabetes Short-Term Complications Admission Rate (PQI 01)											
Age Cohort 1 (18–64 Years) - Admission rate per 100,000 member months ³	8.09	13.48	12.41	13.13	25.84	9.81	20.84	12.76	11.33	14.19	14.66
Age Cohort 2 (65+ Years) - Admission rate per 100,000 member months ³	0.00	0.00	0.00	16.10	9.14	0.00	0.00	0.00	0.00	2.80	1.85
Total 3 (Age 18+ Years) - Admission rate per 100,000 member months ³	8.03	13.41	12.30	13.15	25.73	9.71	20.61	12.65	11.28	14.10	14.57
Congestive Heart Failure Admissions Rate (PQI 08)											

PH-MCO PA Performance Measure	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Age Cohort 1 (18-64 Years) Admission rate per 100,000 member months ³	9.32	10.25	14.39	14.05	23.53	29.15	27.51	22.19	12.82	18.13	19.35
Age Cohort 2 (65+ Years) Admission rate per 100,000 member months ³	10.73	78.80	11.36	48.29	118.87	70.63	74.34	81.60	101.33	66.22	70.24
Total 3 (Age 18+ Years) Admission rate per 100,000 member months ³	9.33	10.58	14.37	14.22	24.14	29.59	28.02	22.69	13.22	18.46	19.74
Developmental Screening in the First Three Years of Life (CHIPRA Measure DEV-CH)											
Rate 1: Total	56.68%	57.11%	47.71%	62.06%	52.73%	45.86%	52.93%	55.01%	67.43%	55.28%	55.69%
Rate 2: 1 year	50.39%	53.11%	38.71%	60.16%	46.90%	37.41%	46.10%	50.74%	64.40%	49.77%	50.26%
Rate 3: 2 years	59.02%	61.25%	52.03%	63.74%	55.33%	52.32%	57.27%	57.55%	69.72%	58.69%	59.11%
Rate 4: 3 years	61.00%	57.61%	53.02%	62.34%	56.78%	47.69%	54.94%	56.63%	68.45%	57.61%	57.93%
Dental Sealants for 6- to 9-Year-Old Children at Elevated Caries Risk (CHIPRA Measure SEAL-CH)											
MCO-Defined	25.21%	24.98%	22.43%	38.44%	23.78%	23.82%	22.79%	21.27%	23.67%	25.15%	24.39%
Dental-Enhanced	30.87%	24.96%	22.53%	38.12%	23.82%	25.14%	22.86%	23.25%	23.54%	26.12%	25.32%
Contraceptive Care for all Women (CCW)											
Provision of most or moderately effective contraception (Ages 15 to 20)	32.70%	38.10%	32.64%	26.98%	35.17%	27.85%	30.67%	25.00%	17.27%	29.60%	28.49%
Provision of LARC contraception (Ages 15 to 20)	4.10%	4.55%	5.90%	3.25%	5.45%	5.69%	4.76%	4.59%	5.95%	4.92%	5.03%
Provision of most or moderately effective contraception (Ages 21 to 44)	26.47%	30.37%	30.67%	21.99%	28.68%	29.81%	30.89%	21.48%	13.05%	25.93%	24.95%
Provision of LARC (Ages 21 to 44)	5.13%	5.92%	7.55%	4.98%	6.32%	7.48%	7.01%	5.76%	6.21%	6.26%	6.39%
Provision of most or moderately effective contraception (Ages 15 to 44)	27.84%	32.08%	31.14%	23.23%	30.33%	29.38%	30.83%	22.45%	13.87%	26.80%	25.79%
Provision of LARC (Ages 15 to 44)	4.90%	5.62%	7.15%	4.55%	6.10%	7.08%	6.43%	5.43%	6.16%	5.94%	6.07%
Contraceptive Care for Postpartum Women (CCP)											
Numerator 1: Most or moderately effective contraception - 3 days (Ages 15 to 20)	5.73%	4.12%	6.78%	8.03%	4.47%	16.31%	13.91%	3.88%	3.22%	7.38%	7.62%
Numerator 2: Most or moderately effective contraception - 60 days (Ages 15 to 20)	41.22%	51.76%	48.13%	36.27%	40.06%	48.16%	45.53%	32.97%	14.41%	39.83%	37.72%
Numerator 3: LARC - 3 days (Ages 15 to 20)	1.43%	0.59%	3.04%	1.30%	0.92%	8.16%	6.95%	1.29%	2.66%	2.93%	3.28%
Numerator 4: LARC - 60 days (Ages 15 to 20)	10.75%	6.47%	16.82%	8.03%	11.25%	18.83%	22.02%	12.50%	9.93%	12.96%	13.68%
Numerator 1: Most or moderately effective contraception - 3 days (Ages 21 to 44)	12.46%	13.96%	15.67%	14.17%	13.08%	17.35%	18.05%	5.44%	11.30%	13.50%	13.78%
Numerator 2: Most or moderately effective contraception - 60 days (Ages 21 to 44)	38.80%	45.13%	50.60%	36.16%	42.57%	51.90%	46.10%	27.57%	23.20%	40.23%	39.35%

PH-MCO PA Performance Measure	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Numerator 3: LARC - 3 days (Ages 21 to 44)	0.90%	0.14%	1.59%	0.54%	0.91%	4.54%	4.15%	1.02%	1.53%	1.70%	2.06%
Numerator 4: LARC - 60 days (Ages 21 to 44)	7.53%	7.12%	12.46%	6.12%	9.69%	14.22%	14.04%	9.47%	9.33%	10.00%	10.60%
Numerator 1: Most or moderately effective contraception - 3 days (Ages 15 to 44)	11.77%	12.91%	14.59%	13.50%	11.96%	17.24%	17.67%	5.24%	10.49%	12.82%	13.11%
Numerator 2: Most or moderately effective contraception - 60 days (Ages 15 to 44)	39.05%	45.84%	50.30%	36.18%	42.25%	51.51%	46.05%	28.27%	22.32%	40.20%	39.17%
Numerator 3: LARC - 3 days (Ages 15 to 44)	0.95%	0.19%	1.77%	0.62%	0.92%	4.92%	4.41%	1.06%	1.64%	1.83%	2.19%
Numerator 4: LARC - 60 days (Ages 15 to 44)	7.86%	7.05%	12.99%	6.33%	9.89%	14.70%	14.77%	9.86%	9.39%	10.32%	10.93%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%) (HPCMI-AD)											
Ages 18 – 64 years	89.16%	96.79%	86.61%	97.04%	68.55%	86.38%	93.54%	91.48%	87.76%	88.59%	87.24%
Ages 65 – 75 years*	100.00%*	100.00%*	40.00%*	NA*	71.43%*	71.43%*	100.00%*	100.00%*	100.00%*	85.36%	86.36%
Age Total	89.26%	96.82%	86.32%	97.04%	68.59%	86.30%	93.60%	91.52%	87.87%	88.59%	87.23%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)											
Ages 1 – 5 years*	0.00%*	0.00%*	80.00%*	60.00%*	66.67%*	80.00%*	33.33%*	66.67%*	60.00%*	49.63%	60.71%
Ages 6 – 11 years	72.16%	75.00%	72.67%	71.67%	77.40%	78.87%	65.03%	68.04%	74.89%	72.86%	72.65%
Ages 12 – 17 years	74.21%	62.07%	68.29%	67.81%	72.58%	76.15%	65.36%	67.11%	72.24%	69.54%	69.63%
Ages Total	72.59%	66.89%	70.33%	69.16%	74.24%	77.30%	65.08%	67.46%	73.00%	70.67%	70.61%
Follow-up After Emergency Department (ED) Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (FUA/FUM)											
FUA: Ages 18 – 64 (7 days)	15.47%	11.32%	14.14%	14.37%	15.02%	12.01%	16.62%	15.35%	18.05%	14.71%	15.33%
FUA: Ages 18 – 64 (30 days)	22.52%	19.73%	21.38%	22.17%	22.17%	19.60%	25.62%	21.86%	27.14%	22.47%	23.24%
FUA: Ages 65+ (7 days)*	NA*	NA*	25.00%*	NA*	25.00%*	0.00%*	0.00%*	33.33%*	0.00%*	13.89%	13.64%
FUA: Ages 65+ (30 days)*	NA*	NA*	50.00%*	NA*	50.00%*	40.00%*	0.00%*	33.33%*	0.00%*	28.89%	31.82%
FUM: Ages 18 – 64 (7 days)	35.51%	45.45%	36.47%	55.42%	45.13%	20.00%	25.00%	25.29%	38.79%	36.34%	35.34%
FUM: Ages 18 – 64 (30 days)	51.40%	60.61%	49.41%	63.86%	59.29%	31.76%	35.26%	41.38%	60.00%	50.33%	49.67%
FUM: Ages 65+ (7 days)*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FUM: Ages 65+ (30 days)*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

* Some denominators contained fewer than 30 members. Caution should be exercised when interpreting results for small denominators, as they produce rates that are less stable.

¹ Lower rate indicates better performance for three measures that are related to live births: Cesarean Rate for Nulliparous Singleton Vertex, Percent of Live Births Weighing Less than 2,500 Grams (Positive), and Elective Delivery.

² For the Reducing Potentially Preventable Readmissions measure, lower rates indicate better performance.

³ For the Adult Admission Rate measures, lower rates indicate better performance.

CHIP-MCO Performance Measures

Each CHIP-MCO underwent a full HEDIS Compliance Audit in 2018. 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® 2018: Volume 2: Technical Specifications*. All the CHIP-MCO HEDIS rates are compiled and provided to DHS CHIP on an annual basis. **Table 9** represents the HEDIS performance for all 10 CHIP-MCOs in 2018, as well as the CHIP mean and the CHIP weighted average.

Table 9 is the full set of HEDIS 2018 measures reported to DHS CHIP. The individual MCO 2018 EQR reports include these measures.

Table 9: CHIP-MCO HEDIS 2018 Measure Results

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)												
WCC: BMI Ages 3-11 years	81.03%	82.78%	81.42%	74.67%	85.91%	85.58%	71.73%	62.30%	85.77%	80.91%	79.21%	80.75%
WCC: BMI Ages 12-17 years	78.48%	78.77%	83.54%	74.17%	77.91%	80.38%	66.32%	64.22%	89.53%	78.99%	77.23%	78.82%
WCC: BMI Ages 3-17 years Total Rate	80.05%	80.93%	82.29%	74.47%	81.62%	83.33%	69.01%	63.29%	87.35%	80.28%	78.26%	79.96%
WCC: Nutrition Ages 3-11 years	76.28%	74.64%	70.35%	81.33%	78.52%	76.44%	72.25%	64.40%	84.94%	78.01%	75.72%	77.63%
WCC: Nutrition Ages 12-17 years	72.15%	68.16%	71.52%	81.46%	75.58%	71.52%	74.09%	65.20%	88.95%	71.43%	74.01%	75.65%
WCC: Nutrition Ages 3-17 years Total Rate	74.70%	71.65%	70.83%	81.38%	76.95%	74.32%	73.18%	64.81%	86.62%	75.83%	75.03%	76.90%
WCC: Physical Activity Ages 3-11 years	67.98%	63.64%	64.60%	71.11%	77.18%	68.27%	64.92%	58.12%	76.15%	73.86%	68.58%	70.41%
WCC: Physical Activity Ages 12-17 years	70.89%	67.60%	68.35%	76.16%	76.16%	68.99%	73.58%	65.20%	90.70%	67.23%	72.48%	74.35%
WCC: Physical Activity Ages 3-17 years Total Rate	69.10%	65.46%	66.15%	73.14%	76.64%	68.58%	69.27%	61.77%	82.24%	71.67%	70.40%	72.29%
Childhood Immunization Status (CIS)												
CIS: DtaP	82.24%	86.27%	87.87%	83.50%	90.91%	89.52%	91.16%	89.04%	85.89%	86.13%	87.25%	86.54%
CIS: IPV	85.98%	90.98%	93.49%	87.86%	96.10%	94.35%	93.95%	90.41%	92.70%	91.73%	91.76%	91.77%
CIS: MMR	89.72%	91.37%	92.90%	90.78%	94.81%	94.35%	92.56%	89.04%	92.21%	92.21%	92.00%	92.03%
CIS: HiB	87.85%	90.59%	92.60%	90.29%	94.81%	94.35%	96.28%	91.78%	93.67%	92.94%	92.52%	92.64%
CIS: Hepatitis B	83.18%	90.59%	94.38%	88.83%	96.10%	90.32%	91.16%	89.04%	93.19%	90.27%	90.71%	91.10%
CIS: VZV	88.32%	90.98%	90.83%	93.20%	96.10%	93.55%	95.81%	90.41%	93.19%	91.73%	92.41%	92.26%
CIS: Pneumococcal Conjugate	83.64%	87.06%	88.46%	85.44%	89.61%	90.32%	91.16%	87.67%	86.37%	86.86%	87.66%	87.17%
CIS: Hepatitis A	85.98%	85.49%	81.66%	91.26%	92.21%	85.48%	94.42%	73.97%	90.75%	89.29%	87.05%	88.22%
CIS: Rotavirus	71.03%	78.04%	79.88%	80.10%	84.42%	79.03%	85.12%	80.82%	80.05%	81.27%	79.98%	79.91%
CIS: Influenza	60.75%	57.25%	45.56%	65.05%	54.55%	58.87%	77.21%	56.16%	63.02%	59.12%	59.75%	60.07%
CIS: Combination 2	78.50%	82.35%	81.66%	77.67%	89.61%	85.48%	79.07%	80.82%	82.24%	82.00%	81.94%	81.58%
CIS: Combination 3	77.57%	81.96%	79.29%	75.73%	85.71%	82.26%	77.67%	80.82%	79.56%	79.56%	80.01%	79.49%
CIS: Combination 4	76.17%	77.65%	73.37%	74.76%	84.42%	78.23%	74.88%	67.12%	78.35%	77.62%	76.26%	76.72%
CIS: Combination 5	67.76%	72.94%	68.93%	68.45%	77.92%	70.16%	72.09%	72.60%	68.37%	72.75%	71.20%	70.46%

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average
CIS: Combination 6	54.67%	54.51%	42.01%	56.31%	51.95%	56.45%	63.26%	50.68%	56.69%	53.53%	54.01%	54.11%
CIS: Combination 7	66.82%	70.59%	64.50%	67.96%	77.92%	68.55%	70.23%	60.27%	67.40%	71.78%	68.60%	68.63%
CIS: Combination 8	53.27%	52.55%	40.53%	55.83%	51.95%	54.84%	62.33%	47.95%	56.69%	53.53%	52.95%	53.40%
CIS: Combination 9	49.53%	49.41%	37.28%	52.91%	49.35%	47.58%	59.07%	47.95%	50.85%	49.64%	49.36%	49.27%
CIS: Combination 10	48.60%	48.63%	35.80%	52.43%	49.35%	45.97%	59.07%	45.21%	50.85%	49.64%	48.56%	48.78%
Immunizations for Adolescents (IMA)												
IMA: Meningococcal	88.08%	88.32%	90.75%	89.49%	91.97%	92.21%	92.94%	92.34%	91.24%	90.27%	90.76%	90.78%
IMA: Tdap/Td	91.48%	94.89%	92.21%	91.69%	93.19%	93.97%	95.38%	93.15%	91.00%	93.43%	93.04%	93.02%
IMA: HPV	32.60%	29.20%	24.33%	38.88%	29.68%	28.64%	38.44%	24.19%	39.66%	25.79%	31.14%	32.27%
IMA: Combination 1	86.13%	87.59%	88.56%	88.02%	91.48%	91.46%	92.46%	90.73%	88.56%	90.02%	89.50%	89.52%
IMA: Combination 2	29.68%	26.76%	22.87%	36.67%	29.20%	27.64%	35.52%	22.58%	38.20%	24.33%	29.35%	30.46%
Lead Screening in Children (LSC)												
LSC: Rate	65.42%	35.69%	70.41%	72.82%	59.74%	37.90%	62.04%	45.21%	66.18%	65.21%	58.06%	61.91%
Chlamydia Screening in Women (CHL)												
CHL: Ages 16-19 years	38.86%	31.40%	35.74%	50.26%	29.07%	31.17%	56.41%	33.33%	42.19%	33.02%	38.14%	38.58%
CHL: Total Rate	38.86%	31.40%	35.74%	50.26%	29.26%	31.17%	56.41%	33.33%	42.19%	33.02%	38.16%	38.59%
Respiratory Conditions												
Appropriate Testing for Children with Pharyngitis (CWP)												
CWP: Rate	87.53%	83.66%	87.83%	81.77%	89.08%	87.31%	89.08%	79.71%	83.46%	90.20%	85.96%	86.70%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)												
URI: Rate	92.77%	88.29%	91.84%	93.98%	85.30%	88.91%	92.65%	81.30%	90.65%	87.95%	89.36%	89.71%
Medication Management for People With Asthma (MMA)												
MMA: Medication Compliance 50% Ages 5-11 years	60.00%	65.22%	66.67%	51.61%	63.64%	57.75%	59.49%	65.22%	59.36%	54.96%	60.39%	59.54%
MMA: Medication Compliance 50% Ages 12-18 years	55.56%	56.18%	61.40%	63.64%	66.13%	67.69%	54.81%	68.57%	52.07%	60.00%	60.60%	58.96%
MMA: Medication Compliance 50% Ages 19 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MMA: Medication Compliance 50% Total Rate	57.80%	60.77%	64.39%	56.60%	65.74%	62.77%	57.14%	67.24%	56.73%	57.31%	60.65%	59.35%
MMA: Medication Compliance 75% Ages 5-11 years	34.55%	41.30%	44.00%	29.03%	40.91%	39.44%	36.71%	43.48%	31.96%	29.77%	37.11%	35.39%
MMA: Medication Compliance 75% Ages 12-18 years	25.93%	29.21%	33.33%	29.55%	48.39%	41.54%	31.85%	34.29%	34.71%	36.80%	34.56%	34.56%
MMA: Medication Compliance 75% Ages 19 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
MMA: Medication Compliance 75% Total Rate	30.28%	35.36%	39.39%	29.25%	45.37%	40.88%	34.35%	37.93%	33.04%	33.08%	35.89%	35.15%
Behavioral Health												
Follow-up Care for Children Prescribed ADHD Medication (ADD)												

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average
ADD: Initiation Phase	40.00%	35.82%	50.00%	36.21%	60.00%	46.34%	43.14%	62.07%	54.04%	63.71%	49.13%	50.15%
ADD: Continuation and Maintenance Phase	16.67%	29.03%	55.00%	33.33%	71.43%	33.33%	61.11%	88.89%	56.67%	78.02%	52.35%	62.64%
Follow up After Hospitalization for Mental Illness (FUH)												
FUH: 7 Days	42.50%	60.27%	45.00%	56.52%	47.37%	54.29%	53.00%	61.11%	51.69%	59.70%	53.15%	53.63%
FUH: 30 Days	57.50%	86.30%	75.00%	73.91%	73.68%	91.43%	65.00%	66.67%	77.97%	85.07%	75.25%	77.34%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)												
APM: Ages 1-5 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
APM: Ages 6-11 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
APM: Ages 12-17 years	NA	61.11%	NA	NA	NA	NA	NA	NA	NA	NA	61.11%	61.11%
APM: Ages 1-17 years Total Rate	NA	59.52%	58.82%	NA	NA	NA	20.00%	NA	38.89%	52.50%	45.95%	47.25%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)												
APC: Ages 1-5 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
APC: Ages 6-11 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
APC: Ages 12-17 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
APC: Ages 1-17 years Total Rate	NA	0.00%	NA	NA	NA	NA	NA	NA	NA	0.00%	0.00%	0.00%
Access/Availability of Care												
Children and Adolescents' Access to Primary Care Practitioners (CAP)												
CAP: Ages 12-24 months	97.41%	96.55%	97.99%	94.59%	100.00%	100.00%	98.36%	97.56%	98.51%	99.69%	98.07%	98.24%
CAP: Ages 25 months-6 years	93.00%	93.20%	93.89%	92.90%	93.94%	95.16%	94.29%	94.15%	94.30%	95.65%	94.05%	94.30%
CAP: Ages 7-11 years	96.15%	96.51%	96.79%	95.98%	97.01%	98.38%	97.43%	96.48%	96.93%	97.00%	96.87%	96.92%
CAP: Ages 12-19 years	95.31%	96.79%	96.56%	95.56%	97.23%	98.28%	97.33%	97.45%	96.18%	96.30%	96.70%	96.66%
Annual Dental Visits (ADV)												
ADV: Ages 2-3 years	56.05%	41.83%	37.65%	56.79%	39.09%	40.18%	58.55%	40.87%	47.61%	41.29%	45.99%	46.13%
ADV: Ages 4-6 years	77.88%	80.08%	68.72%	74.26%	79.20%	79.18%	85.32%	78.14%	74.03%	75.79%	77.26%	76.57%
ADV: Ages 7-10 years	81.31%	82.75%	70.31%	77.20%	85.08%	85.19%	86.44%	83.97%	76.45%	76.94%	80.56%	79.36%
ADV: Ages 11-14 years	76.05%	81.22%	66.19%	74.00%	82.18%	82.81%	83.14%	81.36%	72.62%	72.10%	77.17%	76.11%
ADV: Ages 15-18 years	65.12%	75.53%	56.72%	61.64%	74.21%	75.72%	70.75%	76.43%	62.18%	64.05%	68.23%	67.27%
ADV: Ages 19 years	42.42%	71.11%	36.67%	60.71%	61.90%	57.14%	64.62%	80.77%	46.00%	63.16%	58.45%	54.63%
ADV: Ages 2-19 years Total Rate	73.32%	76.98%	62.60%	70.83%	77.79%	78.02%	79.16%	77.67%	69.12%	69.28%	73.48%	72.33%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)												
APP: Ages 1-5 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
APP: Ages 6-11 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
APP: Ages 12-17 years	NA	70.97%	NA	NA	NA	NA	NA	NA	NA	NA	70.97%	70.97%
APP: Ages 1-17 years Total Rate	NA	66.67%	NA	NA	NA	NA	65.63%	NA	NA	63.64%	65.31%	65.35%

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average
Use of Services												
Well-Child Visits in the First 15 Months of Life (W15)												
W15: 0 Visits	1.11%	0.00%	0.00%	4.12%	0.00%	0.00%	0.00%	0.00%	0.31%	0.49%	0.60%	0.68%
W15: 1 Visit	1.11%	0.00%	0.00%	1.03%	0.00%	0.00%	0.00%	0.00%	0.31%	0.00%	0.25%	0.29%
W15: 2 Visits	0.00%	1.67%	0.64%	0.00%	4.35%	0.00%	0.00%	0.00%	0.63%	0.00%	0.73%	0.39%
W15: 3 Visits	4.44%	1.67%	1.28%	4.12%	4.35%	0.00%	1.43%	0.00%	1.25%	0.00%	1.85%	1.55%
W15: 4 Visits	11.11%	1.67%	4.49%	3.09%	0.00%	6.06%	2.86%	10.53%	2.81%	2.44%	4.51%	3.78%
W15: 5 Visits	18.89%	11.67%	13.46%	15.46%	26.09%	6.06%	15.71%	26.32%	9.06%	17.07%	15.98%	13.29%
W15: ≥ 6 Visits	63.33%	83.33%	80.13%	72.16%	65.22%	87.88%	80.00%	63.16%	85.63%	80.00%	76.08%	80.02%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)												
W34: Rate 3-6 years	86.13%	85.38%	82.09%	88.80%	83.19%	84.01%	86.22%	81.93%	85.89%	90.42%	85.41%	86.54%
Adolescent Well-Care Visits (AWC)												
AWC: Rate 12-19 years	68.86%	70.62%	63.39%	71.31%	69.54%	67.06%	76.44%	65.74%	73.72%	67.82%	69.45%	70.44%
Ambulatory Care: Total (AMBA)												
AMBA: Outpatient Visits/1,000 MM Ages < 1 year	660.25	752.74	826.28	604.86	740.24	718.41	673.16	620.00	697.03	796.01	708.90	718.33
AMBA: Outpatient Visits/1,000 MM Ages 1-9 years	237.33	306.27	303.81	204.38	297.04	300.35	233.12	265.22	255.11	318.46	272.11	274.02
AMBA: Outpatient Visits/1,000 MM Ages 10-19 years	184.45	284.98	261.59	160.26	281.14	275.31	204.41	233.69	225.73	262.05	237.36	237.47
AMBA: Outpatient Visits/1,000 MM Ages < 1-19 years Total Rate	215.33	297.50	285.40	185.10	288.78	289.51	219.39	248.20	243.23	293.44	256.59	257.70
AMBA: Emergency Department Visits/1,000 MM Ages < 1 year	37.53	40.23	38.00	52.21	48.05	22.86	30.68	15.00	38.35	46.89	36.98	39.40
AMBA: Emergency Department Visits/1,000 MM Ages 1-9 years	29.37	27.63	32.20	33.27	29.99	23.34	28.09	27.81	32.72	34.09	29.85	30.93
AMBA: Emergency Department Visits/1,000 MM Ages 10-19 years	24.68	21.77	30.13	24.36	27.14	18.90	23.68	26.61	27.61	30.86	25.57	26.28
AMBA: Emergency Department Visits/1,000 MM Ages < 1-19 years Total Rate	27.09	24.48	31.18	28.90	28.18	20.92	25.57	27.03	30.13	32.54	27.60	28.50
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)												
IPUA: Total Discharges/1,000 MM Ages < 1 year	2.47	1.46	5.43	3.60	6.01	1.20	4.13	0.00	3.20	3.52	3.10	
IPUA: Total Discharges/1,000 MM Ages 1-9 years	0.73	0.71	0.73	0.72	0.31	0.86	1.50	0.94	0.81	0.65	0.80	
IPUA: Total Discharges/1,000 MM Ages 10-19 years	0.52	0.96	0.82	1.03	0.88	0.74	1.26	0.65	0.92	0.89	0.87	
IPUA: Total Discharges/1,000 MM Ages < 1-19 years Total Rate	0.64	0.85	0.81	0.90	0.72	0.80	1.38	0.76	0.89	0.80	0.86	
IPUA: Total Inpatient ALOS Ages < 1 year	5.00	2.00	2.60	2.75	2.75	1.00	2.43	0.00	6.40	3.50	2.84	

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average
IPIA: Total Inpatient ALOS Ages 1-9 Years	4.08	2.39	2.09	3.18	1.55	2.58	1.89	3.12	2.74	3.28	2.69	
IPIA: Total Inpatient ALOS Ages 10-19 years	4.53	3.59	4.27	3.53	3.44	2.54	2.46	2.36	4.69	3.41	3.48	
IPIA: Total Inpatient ALOS Ages < 1-19 years Total Rate	4.30	3.13	3.24	3.37	3.13	2.55	2.20	2.72	3.88	3.36	3.19	
IPIA: Surgery Discharges/1,000 MM Ages < 1 year	0.00	0.00	1.09	0.00	3.00	0.00	1.77	0.00	0.00	0.59	0.64	
IPIA: Surgery Discharges/1,000 MM Ages 1-9 years	0.17	0.12	0.16	0.09	0.03	0.20	0.31	0.15	0.07	0.20	0.15	
IPIA: Surgery Discharges/1,000 MM Ages 10-19 years	0.18	0.20	0.19	0.31	0.30	0.21	0.38	0.21	0.21	0.32	0.25	
IPIA: Surgery Discharges/1,000 MM Ages < 1-19 years Total Rate	0.17	0.17	0.18	0.20	0.23	0.20	0.36	0.18	0.14	0.26	0.21	
IPIA: Surgery ALOS Ages < 1 year	0.00	0.00	2.00	0.00	4.00	0.00	1.00	0.00	0.00	1.50	0.85	
IPIA: Surgery ALOS Ages 1-9 years	8.73	3.64	2.08	9.67	1.00	4.45	2.71	2.75	5.57	5.02	4.56	
IPIA: Surgery ALOS Ages 10-19 years	6.50	5.70	5.13	5.13	2.90	2.86	2.71	2.33	6.93	4.42	4.46	
IPIA: Surgery ALOS Ages < 1-19 years Total Rate	7.58	5.03	3.71	6.07	2.92	3.56	2.66	2.46	6.62	4.59	4.52	
IPIA: Medicine Discharges/1,000 MM Ages < 1 year	2.47	1.46	4.34	3.60	3.00	1.20	2.36	0.00	3.20	2.93	2.46	
IPIA: Medicine Discharges/1,000 MM Ages 1-9 years	0.55	0.59	0.58	0.64	0.28	0.66	1.19	0.80	0.75	0.45	0.65	
IPIA: Medicine Discharges/1,000 MM Ages 10-19 years	0.30	0.70	0.54	0.67	0.53	0.49	0.81	0.35	0.64	0.48	0.55	
IPIA: Medicine Discharges/1,000 MM Ages < 1-19 years Total Rate	0.45	0.65	0.58	0.67	0.46	0.57	0.98	0.52	0.71	0.49	0.61	
IPIA: Medicine ALOS Ages < 1 year	5.00	2.00	2.75	2.75	1.50	1.00	3.50	0.00	6.40	3.90	2.88	
IPIA: Medicine ALOS Ages 1-9 years	2.63	2.13	2.09	2.31	1.60	2.03	1.67	3.18	2.48	2.53	2.27	
IPIA: Medicine ALOS Ages 10-19 years	3.63	3.08	4.16	2.84	3.81	2.36	2.38	2.00	4.16	2.66	3.11	
IPIA: Medicine ALOS Ages < 1-19 years Total Rate	3.11	2.69	3.10	2.59	3.27	2.17	2.03	2.70	3.39	2.66	2.77	
Mental Health Utilization (MPT)												
MPT: Any Services/1,000 MM Ages 0-12 years - Male	4.56%	7.61%	7.54%	3.99%	10.34%	10.05%	6.90%	7.14%	6.31%	10.56%	7.50%	
MPT: Any Services/1,000 MM Ages 0-12 years - Female	2.84%	5.58%	5.83%	2.80%	8.62%	7.80%	4.55%	5.61%	4.21%	7.07%	5.49%	
MPT: Any Services/1,000 MM Ages 0-12 years - Total Rate	3.71%	6.58%	6.69%	3.40%	9.48%	8.93%	5.73%	6.38%	5.27%	8.83%	6.50%	
MPT: Any Services/1,000 MM Ages 13-17 years - Male	4.92%	10.46%	9.48%	3.35%	11.62%	11.11%	7.43%	10.22%	7.37%	13.30%	8.93%	
MPT: Any Services/1,000 MM Ages 13-17 years - Female	9.35%	17.14%	15.32%	6.30%	17.95%	20.68%	13.73%	16.78%	12.52%	20.62%	15.04%	

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average
MPT: Any Services/1,000 MM Ages 13-17 years - Total Rate	7.12%	13.77%	12.38%	4.79%	14.78%	15.89%	10.61%	13.56%	9.91%	16.97%	11.98%	
MPT: Inpatient/1,000 MM Ages 0-12 years - Male	0.08%	0.04%	0.02%	0.05%	0.04%	0.06%	0.03%	0.06%	0.04%	0.08%	0.05%	
MPT: Inpatient/1,000 MM Ages 0-12 years - Female	0.04%	0.09%	0.05%	0.08%	0.04%	0.03%	0.06%	0.06%	0.03%	0.09%	0.06%	
MPT: Inpatient/1,000 MM Ages 0-12 years - Total Rate	0.06%	0.06%	0.03%	0.07%	0.04%	0.04%	0.04%	0.06%	0.04%	0.09%	0.05%	
MPT: Inpatient/1,000 MM Ages 13-17 years - Male	0.28%	0.52%	0.22%	0.32%	0.23%	0.13%	0.17%	0.29%	0.20%	0.70%	0.31%	
MPT: Inpatient/1,000 MM Ages 13-17 years - Female	0.86%	0.79%	0.93%	0.60%	0.69%	0.39%	0.58%	0.56%	0.83%	1.49%	0.77%	
MPT: Inpatient/1,000 MM Ages 13-17 years - Total Rate	0.57%	0.66%	0.57%	0.45%	0.46%	0.26%	0.37%	0.43%	0.51%	1.10%	0.54%	
MPT: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 0-12 years - Male	0.08%	0.11%	0.05%	0.08%	0.00%	0.03%	0.11%	0.00%	0.10%	0.25%	0.08%	
MPT: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 0-12 years - Female	0.00%	0.00%	0.02%	0.05%	0.00%	0.03%	0.10%	0.00%	0.04%	0.11%	0.04%	
MPT: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 0-12 years - Total Rate	0.04%	0.06%	0.03%	0.07%	0.00%	0.03%	0.11%	0.00%	0.07%	0.18%	0.06%	
MPT: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 13-17 years - Male	0.09%	0.19%	0.05%	0.19%	0.06%	0.19%	0.28%	0.00%	0.06%	0.55%	0.17%	
MPT: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 13-17 years - Female	0.24%	0.45%	0.00%	0.33%	0.17%	0.52%	0.47%	0.09%	0.14%	1.20%	0.36%	
MPT: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 13-17 years - Total Rate	0.17%	0.32%	0.03%	0.26%	0.11%	0.36%	0.37%	0.05%	0.10%	0.87%	0.26%	
MPT: Outpatient/1,000 MM Ages 0-12 years - Male	4.42%	7.50%	7.47%	3.85%	10.30%	9.99%	6.80%	7.08%	6.15%	10.47%	7.40%	
MPT: Outpatient/1,000 MM Ages 0-12 years - Female	2.80%	5.47%	5.76%	2.67%	8.62%	7.78%	4.43%	5.61%	4.12%	7.03%	5.43%	
MPT: Outpatient/1,000 MM Ages 0-12 years - Total Rate	3.63%	6.47%	6.62%	3.27%	9.45%	8.88%	5.62%	6.36%	5.14%	8.77%	6.42%	
MPT: Outpatient/1,000 MM Ages 13-17 years - Male	4.50%	9.86%	9.16%	2.85%	11.39%	10.86%	7.10%	9.93%	7.06%	13.03%	8.57%	
MPT: Outpatient/1,000 MM Ages 13-17 years - Female	8.25%	16.24%	14.44%	5.31%	17.32%	20.09%	13.07%	16.40%	11.40%	20.17%	14.27%	
MPT: Outpatient/1,000 MM Ages 13-17 years - Total Rate	6.36%	13.02%	11.78%	4.05%	14.35%	15.47%	10.11%	13.23%	9.20%	16.61%	11.42%	
MPT: ED/1,000 MM Ages 0-12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.02%	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
MPT: ED/1,000 MM Ages 0-12 years - Female	0.00%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	
MPT: ED/1,000 MM Ages 0-12 years - Total Rate	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.02%	0.00%	0.00%	
MPT: Telehealth/1,000 MM 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%	
MPT: Telehealth/1,000 MM 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%	
MPT: Telehealth/1,000 MM 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%	
MPT: Telehealth/1000 MM Ages 13-17 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
MPT: Telehealth/1,000 MM Ages 13-17 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
MPT: Telehealth/1,000 MM Ages 13-17 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%	
MPT: Telehealth/1,000 MM 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%	
Identification of Alcohol and Other Drug Services (IAD)												
IAD: Any Services/1,000 MM Ages 0-12 years - Male	0.00%	0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.06%	0.02%	0.02%	0.01%	
IAD: Any Services/1,000 MM Ages 0-12 years - Female	0.02%	0.00%	0.00%	0.00%	0.04%	0.00%	0.00%	0.00%	0.01%	0.03%	0.01%	
IAD: Any Services/1,000 MM Ages 0-12 years - Total Rate	0.01%	0.02%	0.00%	0.00%	0.02%	0.00%	0.00%	0.03%	0.01%	0.02%	0.01%	
IAD: Any Services/1,000 MM Ages 13-17 years - Male	1.09%	1.67%	0.76%	0.70%	0.92%	0.84%	1.48%	1.46%	1.10%	1.50%	1.15%	
IAD: Any Services/1,000 MM Ages 13-17 years - Female	0.62%	0.79%	1.10%	0.40%	0.46%	0.52%	0.66%	1.22%	0.69%	0.85%	0.73%	
IAD: Any Services/1,000 MM Ages 13-17 years - Total Rate	0.86%	1.24%	0.93%	0.55%	0.69%	0.68%	1.07%	1.34%	0.90%	1.18%	0.94%	
IAD: Inpatient/1,000 MM Ages 0-12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	
IAD: Inpatient/1,000 MM 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/1,000 MM 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: Inpatient/1,000 MM Ages 13-17 years - Male	0.14%	0.41%	0.16%	0.00%	0.06%	0.13%	0.14%	0.19%	0.12%	0.21%	0.16%	
IAD: Inpatient/1,000 MM Ages 13-17 years - Female	0.29%	0.26%	0.22%	0.00%	0.17%	0.06%	0.19%	0.37%	0.20%	0.16%	0.19%	
IAD: Inpatient/1,000 MM Ages 13-17 years - Total Rate	0.21%	0.34%	0.19%	0.00%	0.11%	0.10%	0.17%	0.29%	0.16%	0.18%	0.18%	
IAD: Intensive Outpatient/Partial Hospitalization/1,000 MM 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%	

CHIP-MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average
IAD: Intensive Outpatient/Partial Hospitalization/1,000 MM 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/1,000 MM 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/1,000 MM Ages 13-17 years - Male	0.00%	0.00%	0.00%	0.00%	0.06%	0.06%	0.06%	0.00%	0.00%	0.08%	0.03%	
IAD: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 13-17 years - Female	0.00%	0.08%	0.00%	0.00%	0.00%	0.00%	0.11%	0.00%	0.00%	0.08%	0.03%	
IAD: Intensive Outpatient/Partial Hospitalization/1,000 MM Ages 13-17 years - Total Rate	0.00%	0.04%	0.00%	0.00%	0.03%	0.03%	0.08%	0.00%	0.00%	0.08%	0.03%	
IAD: Outpatient/1,000 MM Ages 0-12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.06%	0.01%	0.01%	0.01%	
IAD: Outpatient/1,000 MM Ages 0-12 years - Female	0.00%	0.00%	0.00%	0.00%	0.04%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%	
IAD: Outpatient/1,000 MM Ages 0-12 years - Total Rate	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.03%	0.01%	0.02%	0.01%	
IAD: Outpatient/1,000 MM Ages 13-17 years - Male	0.62%	1.04%	0.43%	0.44%	0.74%	0.52%	0.84%	1.17%	0.61%	0.99%	0.74%	
IAD: Outpatient/1,000 MM Ages 13-17 years - Female	0.19%	0.38%	0.82%	0.13%	0.17%	0.32%	0.16%	0.75%	0.34%	0.47%	0.37%	
IAD: Outpatient/1,000 MM Ages 13-17 years - Total Rate	0.40%	0.71%	0.63%	0.29%	0.46%	0.42%	0.50%	0.96%	0.48%	0.73%	0.56%	
IAD: ED/1,000 MM Ages 0-12 years - Male	0.00%	0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.01%	
IAD: ED/1,000 MM Ages 0-12 years - Female	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	
IAD: ED/1,000 MM Ages 0-12 years - Total Rate	0.01%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
IAD: ED/1,000 MM Ages 13-17 years - Male	0.33%	0.26%	0.22%	0.25%	0.06%	0.13%	0.50%	0.29%	0.37%	0.27%	0.27%	
IAD: ED/1,000 MM Ages 13-17 years - Female	0.14%	0.11%	0.05%	0.27%	0.12%	0.26%	0.22%	0.19%	0.14%	0.21%	0.17%	
IAD: ED/1,000 MM Ages 13-17 years - Total Rate	0.24%	0.19%	0.14%	0.26%	0.09%	0.19%	0.36%	0.24%	0.26%	0.24%	0.22%	
IAD: Telehealth/1,000 MM 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: Telehealth/1,000 MM 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/1,000 MM 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: Telehealth/1,000 MM Ages 13-17 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: Telehealth/1,000 MM Ages 13-17 years - Female	0.00%	0.00%	0.00%	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: Telehealth/1,000 MM Ages 13-17 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%	

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

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

PA Performance Measure results are presented for each CHIP-MCO in **Table 10**, along with the CHIP average and CHIP weighted average, which takes into account the proportional relevance of each MCO.

Table 10: CHIP-MCO PA Performance Measure 2018 (Measurement Year 2017) Results

CHIP-MCO PA Performance Measure	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	8.75%	4.55%	4.76%	11.18%	6.22%	3.55%	9.80%	6.62%	8.77%	7.12%	7.13%	7.71%
Contraceptive Care for Postpartum Women Ages 15-20												
Most or moderately effective contraception - 3 days*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Most or moderately effective contraception - 60 days*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
LARC - 3 days*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
LARC - 60 days*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Contraceptive Care for Women Ages 15-20												
Provision of most or moderately effective contraception	21.73%	2.86%	21.65%	17.79%	32.66%	27.89%	14.43%	30.77%	18.52%	13.14%	20.14%	17.93%
Provision of LARC	2.43%	1.78%	1.96%	2.43%	2.01%	2.14%	1.56%	1.67%	2.35%	3.65%	2.20%	2.27%
Dental Sealants for 6- to 9-Year-Old Children at Elevated Caries Risk												
CHIPRA	26.81%	31.11%	36.72%	22.79%	19.94%	16.59%	24.40%	25.56%	22.09%	27.06%	25.31%	25.21%
CHIPRA: Dental-Enhanced	26.40%	31.11%	36.54%	22.66%	19.58%	16.63%	24.53%	25.50%	22.32%	27.02%	25.23%	25.17%
Developmental Screening in the First Three Years of Life												

CHIP-MCO PA Performance Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	CHIP Average	CHIP Weighted Average
1 Year	37.50%	30.91%	68.94%	40.00%	34.78%	17.39%	54.17%	12.50%	50.00%	56.44%	40.26%	50.15%
2 Years	56.74%	40.78%	40.21%	58.45%	64.56%	49.60%	71.51%	47.95%	56.66%	65.01%	55.15%	56.36%
3 Years	64.64%	33.71%	37.08%	46.03%	60.00%	34.01%	67.18%	26.09%	52.00%	59.72%	48.05%	51.41%
Total	59.61%	35.84%	43.94%	49.50%	58.88%	38.55%	67.40%	34.68%	53.72%	61.22%	50.34%	53.11%

* Some denominators contained fewer than 30 members. Caution should be exercised when interpreting results for small denominators, as they produce rates that are less stable.

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

In accordance with OMHSAS, BH-MCOs are not required to complete a HEDIS Compliance Audit. BH-MCOs and HC BH contractors are required to calculate Pennsylvania Performance Measures, which are validated annually by IPRO. For 2018 (MY 2017), these measures were: Follow-up After Hospitalization for Mental Illness (both HEDIS and Pennsylvania-specific) and Readmission Within 30 Days of Inpatient Psychiatric Discharge. Beginning in MY 2013, OMHSAS adopted HEDIS percentiles as performance goals for the HEDIS follow-up indicators. In 2014, the three-year OMHSAS goal was to achieve the 75th percentile for ages 6-64 based on the annual HEDIS published percentiles for 7-day and 30-day FUH indicators by MY 2017. Additionally, for MY 2014 through 2017, BH-MCOs were given annual interim goals for the 7- and 30-day follow-up rates based on the previous year's results. MY 2017 performance measure results are presented in **Table 11** 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 11: BH-MCO Performance Measure Results for Measurement Year 2017

BH-MCO Performance Measure	CBH	CCBH	MBH	PerformCare	VBH	BH MMC Average	BH MMC Weighted Average
HEDIS Follow-up After Hospitalization for Mental Illness							
Within 7 Days – Ages 6-64	30.7%	45.1%	35.3%	39.2%	39.5%	38.0%	39.3%
Within 30 Days – Ages 6-64	46.1%	67.0%	57.9%	62.1%	64.8%	59.6%	60.9%
Within 7 Days – All Ages	30.4%	44.9%	35.1%	39.1%	39.4%	37.8%	39.1%
Within 30 Days – All Ages	45.7%	66.9%	57.5%	61.9%	64.6%	59.3%	60.6%
Within 7 Days – Ages 6-20	49.7%	54.8%	44.2%	53.7%	49.3%	50.3%	51.1%
Within 30 Days – Ages 6-20	66.4%	77.5%	68.5%	75.8%	76.5%	72.9%	74.0%
Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness							
Within 7 Days – All Ages	49.5%	56.9%	47.6%	51.4%	49.6%	51.0%	52.2%
Within 30 Days – All Ages	63.4%	74.0%	63.0%	70.9%	72.0%	68.7%	69.6%
Readmission Within 30 Days of Inpatient Psychiatric Discharge							
Rate	12.9%	13.3%	15.7%	11.1%	13.1%	13.2%	13.4%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment							
Initiation of AOD Treatment – Ages 13-17	55.3%	45.4%	37.9%	46.2%	46.1%	46.2%	46.3%
Engagement of AOD Treatment – Ages 13-17	38.6%	34.1%	30.2%	33.8%	36.1%	34.6%	34.6%
Initiation of AOD Treatment – Ages 18+	36.0%	42.9%	36.2%	39.0%	48.1%	40.4%	41.1%
Engagement of AOD Treatment – Ages 18+	28.5%	35.6%	28.0%	30.1%	42.0%	32.8%	33.7%
Initiation of AOD Treatment – Ages 13+	36.7%	43.0%	36.2%	39.4%	48.0%	40.7%	41.3%
Engagement of AOD Treatment – Ages 13+	28.8%	35.5%	28.1%	30.3%	41.8%	32.9%	33.7%

- BH-MCOs had interim rate goals (calculated using an algorithm) for HEDIS Follow-up After Hospitalization for Mental Illness for ages 6-64. These goals were not met by any BH-MCO for 7- and 30-day rates.
- The BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for these two FUH measures was between the HEDIS 50th and 75th percentiles. Consequently, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for ages 6-64 for both 7- and 30-day rates was not achieved.
- The BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for the two FUH All-Ages (Overall) measures similarly fell below the HEDIS 75th percentile.
- The BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for the two FUH All-Ages measures was statistically significantly lower than the previous year.
- HEDIS Follow-up After Hospitalization for Mental Illness rates for ages 6-20 years was statistically significantly lower than the previous year.
- For the Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness rates, MBH and VBH had significantly lower 7- and 30-day follow-up rates than in MY 2016. The remaining BH-MCOs showed no significant change from MY 2016.
- Rates for Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) did not change significantly from the previous year for any BH-MCO, except for PerformCare and VBH. REA rate for PerformCare decreased (improved) statistically significantly compared to the prior year, while VBH's REA rate increased (worsened) statistically significantly compared to the prior year.
- None of the BH-MCOs met the OMHSAS performance goal of 10% (or lower) for REA.
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment rates for 13-17 year olds improved (increased) statistically significantly from 2016 for all BH-MCOs except MBH, which showed no significant changes.
- IET rates for Ages 18+ saw statistically significant improvements (increases) across all five BH-MCOs. The BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for the Engagement rate for Ages 18+ was above the HEDIS 75th percentile.
- For Initiation and Engagement of Alcohol and Other Drug Dependence Treatment rates (Ages 13+), all MCOs saw significant increases (improvement) in both the Initiation and Engagement rates.

CHC-MCO Performance Measures

The CHC-MCOs must complete all reporting requirements for PMs (which includes HEDIS and CAHPS surveys, PA-specific PMs, and KPMs), and a validation process is conducted by IPRO to ensure that PM results were reasonable and were calculated in accordance with specifications. There was limited information to include for performance measurement in the 2018 BBA report, as no PM results were applicable (2017 was not an applicable measurement period for CHC). At the time of this report, ongoing activities included identifying and communicating measurement capacity to meet PM reporting requirements for reporting validated results in next year's BBA report (with 2018 as the measurement period). For the ongoing activities, 2018 is the measurement period, and results of validated rates will be included as findings in next year's BBA report.

HEDIS PMs for CHC

There were no HEDIS PM results applicable to be reported on for the 2018 BBA report, as 2017 was not an applicable measurement period for CHC. At the time of this report, activities for HEDIS PMs were ongoing to meet requirements for next year's BBA report (in which HEDIS PMs use 2018 as the measurement period).

Selection and description of HEDIS PMs have been established, and a full HEDIS Compliance Audit using HEDIS 2019 specifications (with 2018 as the measurement period) was underway. Development of HEDIS PMs and the clinical rationale for their inclusion in the HEDIS requirements was incorporated. Each year, the DHS OLTL updates its requirements for the CHC-MCOs to be consistent with NCQA's requirements for HEDIS.

Annually, CHC-MCOs must complete all reporting requirements for requisite HEDIS measures designated by NCQA for Medicaid measures, using the Interactive Data Submission System (IDSS). IPRO, on behalf of the DHS OLTL, provided guidance to the CHC-MCOs to comply with HEDIS and CAHPS reporting requirements in 2019. All CHC-MCOs were required to report HEDIS 2019 and CAHPS for 2019. CHC-MCOs were required to adhere to the NCQA deadlines for reporting tasks. Failure to meet NCQA deadlines would result in NCQA being informed, with failure reflection in audit findings. Additionally, all CHC-MCOs were required to have HEDIS results audited by a certified HEDIS audit firm. For this purpose, IPRO retained Aqurate Health Data Management, Inc. as the audit firm for HEDIS and CAHPS 2019.

Specifically, for reporting HEDIS 2019 and CAHPS 2019, CHC-MCOs were required to structure reporting based on three applicable subpopulations, as follows:

1. Medicaid-only members with CHC benefits (i.e., those not also enrolled in Medicare);
2. Dual-eligible members with CHC benefits and Medicare benefits with the same CHC-MCO (i.e., Medicare-Medicaid enrolled, or aligned D-SNP and CHC benefits); and
3. Members who have CHC benefits and Medicare benefits with different MCOs (i.e., D-SNP enrollment unaligned with the CHC-MCO, or the member had another Medicare Advantage or FFS plan).

Each CHC-MCO was required to produce and submit two IDSSs for HEDIS 2019 reporting and two survey sample frames (SSF) for CAHPS reporting in 2019; the first IDSS submission encompassed all required Medicaid measures via the Medicaid IDSS and the second IDSS submission encompassed the two required Medicare measures via a partial Medicare IDSS.

CHC-MCOs were required to report all measures required by NCQA for accreditation; this included HEDIS measures with Medicaid listed as the product line, with several exceptions: measures excluded from the complete Medicaid HEDIS data set were childhood-related and pregnancy-related measures, as well as those which produced rates involving behavioral health (which was carved out in PA); these measures were required to be indicated by the CHC-MCO in the IDSS as no benefit. The reporting was required to be in accordance with HEDIS 2019 product line technical specifications. For this submission, the requirement was to follow the HEDIS 2019 submission timeline. For all three subpopulations, CHC-MCOs were required to indicate on the Healthcare Organization Questionnaire that the HEDIS 2019 submissions through IDSS were for public reporting.

For Subpopulations 1 and 2, measures for HEDIS 2019 reporting for CHC were as follows:

- Adult BMI Assessment (ABA),
- Breast Cancer Screening (BCS),
- Cervical Cancer Screening (CCS),
- Chlamydia Screening in Women (CHL),
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR),

- Pharmacotherapy Management of COPD Exacerbation (PCE),
- Medication Management for People With Asthma (MMA),
- Asthma Medication Ratio (AMR),
- Controlling High Blood Pressure (CBP),
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH),
- Statin Therapy for Patients With Cardiovascular Disease (SPC),
- Comprehensive Diabetes Care (CDC),
- Statin Therapy for Patients With Diabetes (SPD),
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART),
- Antidepressant Medication Management (AMM),
- Follow-up After Hospitalization for Mental Illness (FUH),
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD),
- Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD),
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC),
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA),
- Annual Monitoring for Patients on Persistent Medications (MPM),
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB),
- Use of Imaging Studies for Low Back Pain (LBP),
- Use of Opioids at High Dosage (UOD),
- Use of Opioids From Multiple Providers (UOP),
- Flu Vaccinations for Adults Ages 18-64 (FVA),
- Medical Assistance With Smoking and Tobacco Use Cessation (MSC),
- Adults' Access to Preventive/ Ambulatory Health Services (AAP),
- CAHPS Health Plan Survey 5.0H, Adult Version (CPA),
- Frequency of Selected Procedures (FSP),
- Ambulatory Care (AMB),
- Inpatient Utilization—General Hospital/Acute Care (IPU),
- Antibiotic Utilization (ABX),
- Plan All-Cause Readmissions (PCR),
- Risk of Continued Opioid Use (COU), and
- Adult Immunization Status (AIS).

For Subpopulation 2, measures for HEDIS 2019 reporting for CHC were as follows:

- Care for Older Adults (COA), and
- Transitions of Care (TRC).

For Subpopulation 3, there were no applicable measures for HEDIS 2019 reporting for CHC.

The above lists are measures for the three subpopulations for the Medicaid Product Line (as indicated on the HEDIS 2019 specifications); required measures were listed regardless of continuous enrollment criteria (i.e., a given measure's continuous enrollment window precedes the earliest CHC enrollment). Excluded measures for HEDIS 2019 reporting, not listed in the above, were the four long-term services and supports (LTSS) measures new in 2019 (which included: LTSS Comprehensive Assessment and Update [LTSS-CAU], LTSS Comprehensive Care Plan and Update [LTSS-CPU], LTSS Shared Care Plan with Primary Care Practitioner [LTSS-SCP], and LTSS Reassessment/Care Plan Update After Inpatient Discharge [LTSS-RAC]), four behavioral health measures (which included: Follow-up After Emergency DHS OLTL Visit for Mental Illness [FUM], Follow-up After Emergency DHS OLTL Visit for Alcohol and Other Drug Abuse or Dependence [FUA], Identification of Alcohol and Other Drug Services [IAD], and Mental Health Utilization [MPT], and one measure that was retired in October 2018, per the *HEDIS® 2019 Volume 2: Technical Update* (Standardized Healthcare-Associated Infection Ratio [HAI]).

Per HEDIS 2019 General Guidelines, any managed care organization offering both Medicaid and Medicare-Medicaid dual benefits is required to include the dual-eligible members under the Medicaid reporting for HEDIS. For CHC, all CHC-MCOs offer dual benefits, although not all participants choose to use the same CHC-MCO for their benefits; in order for CHC reporting to follow this general guideline for HEDIS reporting in 2019, CHC-MCOs were informed that measures for Subpopulation 2 were to be combined with Subpopulation 1 and reported via Medicaid IDSS. However, for Subpopulation 2, two measures (Care for Older Adults [COA] and Transitions of Care [TRC]) were required to be reported via submission of a separate, partially completed Medicare IDSS (COA [required for Special Needs Plans and Medicare-Medicaid Plans] and TRC were both Medicare measures and did not apply to Medicaid). For Subpopulation 3, CHC-MCOs did not have access to most claims data that were required for HEDIS reporting if the CHC-MCO offered only CHC benefits to any members. Therefore, there were no measures for Subpopulation 3 for HEDIS 2019 reporting.

As CHC membership began on January 1, 2018, nine measures entailed specifications for continuous enrollment that pre-dated CHC formation; this included the following measures: Adult BMI Assessment (ABA), Breast Cancer Screening (BCS), Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR), Medication Management for People With Asthma (MMA), Asthma Medication Ratio (AMR), Statin Therapy for Patients With Cardiovascular Disease (SPC), Statin Therapy for Patients With Diabetes (SPD), Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD), and Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB). These measures, which required greater than one year of continuous enrollment, were not selected in the Audit Review Table in the IDSS; these measures were assigned an audit status of not required (NQ). For CHC reporting for HEDIS 2019, data were not collected on members who were continuously enrolled in another product within the CHC-MCO prior to the initiation of the CHC program; additionally, the aforementioned new LTSS measures were not required, and were not included.

CAHPS Survey for CHC

There were no results for CAHPS that were applicable to be reported on in the 2018 BBA report, as 2017 was not an applicable sampling period for CHC; subsequent descriptions are ongoing activities for CAHPS to produce results reportable in next year's BBA report.

At the time of this report, activities for CAHPS were ongoing to meet requirements for next year's BBA report (in which CAHPS 2018 as the sampling period). For CAHPS 2019 reporting requirements, NCQA required that HEDIS and CAHPS reporting populations were aligned. Each CHC-MCO was required to produce and submit two SSFs for CAHPS 2019 reporting, as follows:

- One Medicaid Adult CAHPS SSF, which contained Subpopulation 1 and Subpopulation 2 (Subpopulation 2 was combined with Subpopulation 1 and reported via Medicaid Adult CAHPS); and
- One Medicaid Adult CAHPS SSF, which contained Subpopulation 3.

Per agreement with the DHS OLTL, CHC-MCOs were required to submit CAHPS files for Adult Medicaid in accordance with NCQA guidelines; this included composite data from NCQA, as well as record-level data. The Adult CAHPS was required to be completed with the three additional adult dental questions, as well as supplemental items on the Adult Questionnaires for the CAHPS survey.

PA-Specific PMs for CHC

For PA-Specific PMs, there were no methodologies to produce measurement results for the 2018 BBA report. No PA-Specific PMs were applicable to be reported on for the 2018 BBA report, as 2017 was not an applicable measurement period for CHC; subsequent descriptions are ongoing activities to produce PA-Specific PM results reportable in the next year's BBA report.

Activities for PA-Specific PMs were ongoing to meet reporting requirements for inclusion in the 2019 BBA report (in which PMs use 2018 as the measurement period), including ongoing selection and description of PA-specific and key PMs. Annual PA-Specific PMs for CHC additionally included four LTSS measures (Comprehensive Assessment and Update [CAU], Comprehensive Care Plan and Update [CPU], Shared Care Plan With Primary Care Practitioner [SCP], and Reassessment/Care Plan Update After Inpatient Discharge [RAC]), the ADV (Annual Dental Visit), and the AMM (Antidepressant Medication Management during Acute Treatment) measure. For the validation of select PMs, IPRO implemented a protocol that was similar to that conducted across the other PA divisions. Ongoing validation of five KPMs (Inpatient Utilization—General Hospital/Acute Care [IPU], Ambulatory Care [AMB], Plan All Cause Readmissions [PCR], Adherence to Antipsychotic Medications for Individuals with Schizophrenia [SAA], and Number of Schizophrenics on Antipsychotic Medication [SAM]) required the CHC-MCO to submit member-level data files and source code for each measure, effective September 30, 2018. The data files submitted were the fixed-width format provided to the CHC-MCOs; IPRO sent a file layout to the CHC-MCOs for this purpose. The first step in the validation process was a review of the source code for each of the KPMs to identify any questions or discrepancies between the CHC-MCOs' source codes and the KPM specifications. At the same time, IPRO developed a program to import the member-level data file for each measure. IPRO validated the elements in the data file utilizing a validation sheet to document both source code and data file findings; the validation sheet addressed measure demographics, denominator events (as applicable to the specific measures), and the numerator information. Upon identification of any issues or discrepancies, the validation process findings were forwarded to the CHC-MCOs, accompanied by a request for the CHC-MCOs to investigate the discrepancies and respond to IPRO. IPRO also developed logic to summarize and identify the denominator, numerator, and rate for each KPM using the information from the CHC-MCOs' member-level data files. This information was exported to a rate sheet that was finalized upon resolution of all issues, and the KPM was deemed to have passed validation. Final rate sheets were then sent to each of the CHC-MCOs once all of the measures passed validation across each of the CHC-MCOs. During the validation process, IPRO followed up periodically with each of the CHC-MCOs to provide status updates on validation discrepancies or a requested rate explanation. IPRO expected the CHC-MCOs to acknowledge and sign off on final rate sheets. Throughout the validation process, IPRO provided regular status updates to the DHS OLTL.

The CHC-MCOs were also required to submit a Rebalancing KPM (on a quarterly basis) and a Personal Assistance Services (PAS) KPM (on a monthly basis), which was also effective September 30, 2018.

Findings for CHC

For PMs and CAHPS, findings were applicable to be reported on in the 2018 BBA report (2017 was not an applicable time frame for measurement, including for any PMs and for CAHPS survey sampling frames).

At the time of this report, activities for reporting PM and CAHPS findings were ongoing for reporting in accordance with reporting requirements for next year's BBA report, which will include findings on results of PMs and CAHPS using data from the measurement period of 2018. At that time, data will also be available on evidence-based waiver assurance reviews submitted to the DHS OLTL.

Section IV: 2017 Opportunities for Improvement – MCO Response

To achieve full compliance with federal regulations, the PH-MCOs and BH-MCOs were requested to respond to the opportunities for improvement from the prior year's reports. Because 2018 was the first year of technical reports for CHC-MCOs and CHIP-MCOs, the request was not made to these MCOs. A response will be required in 2019 by all applicable MCOs for the noted opportunities for improvement identified in 2018.

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 2017 EQR Technical Reports, which were distributed in April 2018. The 2018 EQR Technical Report is the 11th to include descriptions of current and proposed interventions considered by each MCO that address the prior year recommendations.

Both the PH-MCOs and BH-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 Medicaid MCOs. 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 (BH-MCOs) and August 1 (PH-MCOs), 2018 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 2017, PH-MCOs were required to address those measures on the 2017 Pay for Performance (P4P) Measure Matrix receiving either D or F ratings, while BH-MCOs were required to address those measures that performed statistically significantly poorer than the HealthChoices BH-MCO average (i.e., BH MMC average) and/or as compared to the prior MY. MCOs were required to submit the following for each P4P measure in categories D and F:

- 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 and BH-MCO are detailed in their respective annual technical reports. Corrective action plans that were in place at the OMHSAS level were also forwarded to IPRO for inclusion in the BH-MCO 2018 annual technical reports.

For the CHC program, Phase I of operations started in calendar year (CY) 2018. Prior to operations, no improvement opportunities were applicable in regard to the 2018 BBA report. Starting with next year's BBA report, the CHC-MCOs will respond to identified opportunities for improvement in their current and proposed interventions and submit information to IPRO for review using the same methodology described above.

Section V: 2018 Strengths and Opportunities for Improvement

Overall Strengths

- All PH-MCOs were compliant with all Structure and Operations Standards of Subparts C: Enrollee Rights and Protections Regulations and Subpart F: Federal and State Grievance System Standards.
- All PH-MCOs successfully completed NCQA HEDIS Compliance Audits in 2018, and all PH-MCOs successfully calculated and completed validation of all PA Performance Measures.
- All CHIP-MCOs successfully completed NCQA HEDIS Compliance Audits in 2018, and all CHIP-MCOs successfully calculated and completed validation of all PA Performance Measures.
- All BH-MCOs were compliant with most of the categories in Subpart C: Enrollee Rights and Protection.
- 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 PH-MCOs and BH-MCOs provided responses to the Opportunities for Improvements issued in the 2017 annual technical reports.
- All five BH-MCOs demonstrated HEDIS IET Engagement rates at or above the NCQA Quality Compass® 75th percentile.
- All CHC-MCOs were determined to be sufficiently compliant with standards of quality in accordance with requirements based on the results for the CHC-MCOs' on-site reviews of structural systems and operations readiness, as well as supporting documentation of structural systems and operations readiness.
- All CHC-MCOs were approved to commence operations with enrollment of CHC participants, effective January 1, 2018, based on the determinations of sufficient compliance with standards of quality.

Overall Opportunities

- Four PH-MCOs were partially compliant with some Structure and Operations Standards of Subpart D: Quality Assessment and Performance Improvement Regulations.
- Four CHIP-MCOs were partially compliant with some Structure and Operations Standards of Subparts C: Enrollee Rights and Protections Regulations.
- Five CHIP-MCOs were partially compliant with some Structure and Operations Standards of Subpart D: Quality Assessment and Performance Improvement Regulations.
- Three CHIP-MCOs were partially compliant or not compliant with some Structure and Operations Standards of Subpart H: Certifications and Program Integrity.
- Most BH-MCOs were only partially compliant with many, if not most, of the categories of Subpart D: Quality Assessment and Performance Improvement Regulations.
- All BH-MCOs were only partially compliant with most of the categories of Subpart F: Federal and State Grievance System Standards.
- None of the BH-MCOs met the Quality Compass 75th percentile for the All-Ages/Overall (6+) HEDIS 7-Day or 30-Day Follow-up After Hospitalization for Mental Illness measure.
- None of the BH-MCOs achieved the OMHSAS goal of 10% or less for the Readmission Within 30 Days of Inpatient Psychiatric Discharge measure.
- Two of the BH-MCOs demonstrated IET Initiation rates for the 13+ (Overall) years old population that were below the Quality Compass 25th percentile (CBH and MBH); one performed between the 25th and 50th percentiles (PerformCare); and one performed between the 50th and 75th percentiles (CCBH). Only one of the BH-MCOs, VBH, met the OMHSAS goal of meeting or exceeding the Quality Compass 75th percentile.
- None of the CHC-MCOs had opportunities identified for improvement.

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

Table 12: PH-MCO Root Cause Analysis Measures 2018 (Measurement Year 2017)

Rating	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC
D	Adolescent Well-Care Visits Comprehensive Diabetes Care: HbA1c Poor Control ¹ Prenatal Care in the First Trimester Postpartum Care Reducing Potentially Preventable Readmissions ² Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Medication Management for People With Asthma: 75% Total ³	Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits	Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits	Annual Dental Visit (Ages 2–20 years)	Comprehensive Diabetes Care: HbA1c Poor Control ¹ Controlling High Blood Pressure Prenatal Care in the First Trimester Medication Management for People With Asthma: 75% Total	Reducing Potentially Preventable Readmissions ²		Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Reducing Potentially Preventable Readmissions ² Medication Management for People With Asthma: 75% Total	Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits
F							Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits		

¹ Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.

² Lower rates for Reducing Potentially Preventable Readmissions indicate better performance.

³ In 2018, ABH identified errors with their HEDIS 2017 pharmacy data. The rate reported here is the HEDIS 2017 rate re-calculated by ABH. This rate has not been validated.

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. This change reflected the Commonwealth’s increasing focus on the aging population. A root cause analysis and corresponding action plan was required for any indicator rate that fell below the NCQA Quality Compass 75th percentile for each indicator. Moreover, this root cause analysis and action plan continued a prospective approach that centered on performance goals for CY 2019 calculated in relation to validated MY 2017 results.

Table 13 displays the HEDIS FUH Overall (Ages 6+) performance measure results for each BH-MCO identified as requiring a root cause analysis and action plan for CY 2019:

Table 13: BH-MCO Root Cause Analysis Measures – HEDIS 2018 Indicators

Rating	CBH	CCBH	MBH	PerformCare	VBH
Indicators that are <u>greater than or equal</u> to the 50th percentile but <u>less than</u> the 75th percentile		<p>QI 1 – HEDIS 7-Day Follow-up (Overall)</p> <p>QI 2 – HEDIS 30-Day Follow-up (Overall)</p>		<p>QI 1 – HEDIS 7-Day Follow-up (Overall)</p> <p>QI 2 – HEDIS 30-Day Follow-up (Overall)</p>	<p>QI 1 – HEDIS 7-Day Follow-up (Overall)</p> <p>QI 2 – HEDIS 30-Day Follow-up (Overall)</p>
Indicators that are <u>less than</u> the 50th percentile	<p>QI 1 – HEDIS 7-Day Follow-up (Overall)</p> <p>QI 2 – HEDIS 30-Day Follow-up (Overall)</p>		<p>QI 1 – HEDIS 7-Day Follow-up (Overall)</p> <p>QI 2 – HEDIS 30-Day Follow-up (Overall)</p>		

Section VI: 2017 Adult Community Autism Program (ACAP)

This waiver program is overseen by the Bureau of Autism Services (BAS) and is designed to meet the needs of adults with an autism spectrum disorder. The program is administered by Keystone Autism Services (KAS). KAS provides ambulatory medical services and community and support services to the adults enrolled in the program. As of December 2017, 147 members were enrolled in the program.

Performance Improvement Project

In 2013, KAS undertook a Performance Improvement Project (PIP). This project focused on increasing meaningful engagement outside the home for ACAP enrollees. Three areas were addressed:

1. Increase job and employment retention rates for KAS ACAP enrollees.
2. Improve the proportion of individuals receiving ACAP services who progress from educational and pre-vocational training to an employed status.
3. Increase the proportion of non-engaged individuals who become engaged in some form of enrollment/pre-vocational related service.

The first remeasurement period ended on March 31, 2015. The final measurement period ended on March 31, 2016. KAS submitted a progress report to IPRO for review, which was reported in last year's BBA report. As 2017 was a transition year to a new PIP, there were no PIP activities to report. A new PIP topic 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. The PIP is scheduled to start in 2019.

Performance Measures

KAS submitted documentation for the procedures used to track and report the following measures for MY 2017:

1. Annual Number of Law Enforcement Events
2. Psychiatric Emergency Room Care
3. Psychiatric Inpatient Hospitalization
4. Initial PCP visit within three weeks of enrollment or Annual PCP Visit
5. Annual Dental Exam

IPRO validated the data submitted and procedures used to report all five measures. MY 2017 results are reported in **Table 13**.

Table 14: ACAP Performance Measure Results for Measurement Year 2017

Annual Number of Law Enforcement Events	27 events
Psychiatric Emergency Room Care	8 events
Psychiatric Inpatient Hospitalization	7 events
Initial PCP visit within three weeks of enrollment or Annual PCP Visit	89% of new enrollees
Annual Dental Exam	89%

Annual Monitoring

BAS monitored compliance for 2017 and provided IPRO with a final monitoring report. Findings were presented under the following categories:

- General Information & Organization
 - Description of the Contractor
 - Personnel Requirements
 - Governing Body
 - Plan Advisory Committee
 - Natural Disasters
- Administration
 - Training
 - Program Integrity
 - Participant Records
 - Admittance to an Institution for Mental Disease
 - Moral or Religious Objections to Service
 - Incident Reports
 - Information Systems
 - Federal Requirements
- Providers
 - Provider Selection
 - Contracted Services
 - Primary Care Providers
 - After-Hours Call-in System
 - Provider Monitoring
 - Provider Termination
 - Fiscal Soundness
 - Risk Reserve
 - Insolvency
 - Insurance
 - Cost Avoidance
- Outreach and Marketing
- Services
 - Service Delivery
 - Additional Services
 - Team
 - Individual Service Plan (ISP)
 - Practice Guidelines
 - Service Authorization
 - Timeliness of Services
 - Out-of-Network Services

- Participant Rights, Responsibilities, and Education
 - Explanation of Rights and Responsibilities
 - Education of Providers about Complaints, Grievances, and Fair Hearing Rights
 - Advance Directives
 - Seclusion and Restraint
 - Complaint, Grievance, and DPW Fair Hearings
 - Participant Education
- Quality Assurance and Improvement
 - Plan of Quality Assurance & Improvement
 - Measuring Quality and Improvement
 - Audits of Medical and Service Records
 - Committees
- Participant Enrollment and Disenrollment
 - Eligibility to Enroll
 - Enrollment Process
 - Identification Card Sleeve/Sticker
 - Disenrollment
- Payment
 - Participant Liability
- Data Collection, Record Maintenance & Reporting
 - Maintenance of Records
 - Confidentiality
 - Reporting Requirements

Monitoring includes administrative review of organizational structure, policies, and procedures, as well as a review of a sample of individual service plans (ISPs) for participants. Twenty ISPs were audited for MY 2017.

Most ISPs reviewed adequately met requirements for team composition, development of ISP using a person-centered planning process, inclusion of covered services and informal supports, inclusion of non-covered services paid for by the contractor, justification for services, and the completion of the FBA-based ISP within 60 days of the initial ISP. Findings were presented covering the following areas: ISP Quality; Goals and Objectives; Functional Behavioral Assessment (FBA), Behavioral Support Plan (BSP), Crisis Intervention Plan (CIP), and Medication Therapeutic Management Plan; and Authorized Services. In 2017, BAS introduced the Periodic Risk Evaluation (PRE) as a required assessment. The purpose of the PRE is to identify risks in order to inform planning, monitoring, tracking, and risk mitigation. This year, an additional question was added to the monitoring checklist to assure that the PRE was completed and that the ISP adequately addressed the risks identified on the PRE.

A decline in updated medical information and needs related to safety risk factors in the ISPs, which was first noted last year, continued in 2017. This was probably due, in part, to the implementation of the PRE, which revealed a lack of documentation related to identifying and mitigating risks. This continues to be an area for improvement. Overall, the percentage of audited ISPs meeting full criteria did increase to 53%, with improvements in areas such as employment information, although the percentage of plans adequately documenting SIBR strengths and needs decreased.

One of the two audited ISPs with four or more prescribed psychotropic medications lacked a medication therapeutic management plan with the input of a pharmacist. KAS indicated their plan to secure a new PharmD no later than September 1, 2018. Other deficiencies were found related to the Goals/Objectives, BSAs, and the BSPs.

BAS identified the upcoming implementation of the Systematic Skill Building (SSB) and Goal Attainment Scaling (GAS) tools as remediation strategies. KAS also noted it was implementing trainings around these tools, along with periodic monitoring and assistance, as needed, by the clinical director. Some additional deficiencies under the Provider areas included insufficient documentation, including discharge records; one deficiency was also noted for timely notification of a decision on service authorization.

KAS responded to all recommendations and requests for remediation noted by BAS. All KAS responses were accepted as addressing the issues identified.

Final Project Reports

Upon request, the following reports can be made available:

1. Individual PH-MCO BBA reports for 2018
2. Individual CHIP-MCO BBA reports for 2018
3. Individual BH-MCO BBA reports for 2018
4. Individual CHC-MCO BBA reports for 2018
5. Individual CHC-MCO 2017 Readiness Review reports for 2018
6. Individual CHC-MCO reviews of PIP proposals for 2018
7. Follow-up After Hospitalization for Mental Illness External Quality Review Aggregate Data Tables – Measurement Year 2017 (BH-MCOs), and Report – Measurement Years 2016 and 2017
8. Readmission Within 30 Days of Inpatient Psychiatric Discharge External Quality Review Aggregate Data Tables – Measurement Year 2017 (BH-MCOs)
9. HEDIS 2018 Member-Level Data Reports, Data Analysis Trends (PH-MCOs)
10. HEDIS 2018 Member-Level Data Reports, Data Findings by Measure (PH-MCOs)
11. HEDIS 2018 Member-Level Data Reports, Year-to-Year Data Findings – Southeast Zone/Region (PH-MCOs)
12. HEDIS 2018 Member-Level Data Reports, Year-to-Year Data Findings – Southwest Zone/Region (PH-MCOs)
13. HEDIS 2018 Member-Level Data Reports, Year-to-Year Data Findings – Lehigh/Capital Zone/Region (PH-MCOs)
14. HEDIS 2018 Member-Level Data Reports, Year-to-Year Data Findings – New West Zone/Region (PH-MCOs)
15. Medicaid Managed Care (MMC) Performance Measures, Examination of Year-to-Year Statistical Comparisons for MMC Weighted Averages (PH-MCOs)
16. Medicaid Managed Care Performance Measure Matrices (PH-MCOs and BH-MCOs)
17. 2018 PA CHIP CAHPS 5.0 Rate Table and Results by Item
18. 2018 CHIP Report Card

Note: Reports 7 and 8 display data by MMC, BH-MCO, County, Region (report 8 only), Gender, Age, Race, and Ethnicity.
Reports 9 through 14 display data by MMC, PH-MCO, Region, Race, and Ethnicity.