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External Quality Review Annual Technical Report

April 2024

Review Period: January 1, 2023–December 31, 2023

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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I. Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care organizations (MCOs). *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as "the degree to which an MCO, PIHP,[1] PAHP,[2] or PCCM[3] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

To comply with *Title 42 CFR § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Pennsylvania (PA) Department of Human Services (DHS) contracted with IPRO, an EQRO, to conduct the federal fiscal year (FFY) 2023 EQR activities for the managed care organizations contracted to furnish Medicaid and Children's Health Insurance Program (CHIP) services in the state. This report presents aggregate and MCO-level results of these EQR activities.

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

Introduction

This report is a summary of Medicaid managed care (MMC) and CHIP external quality review (EQR) findings for PA's behavioral health (BH), physical health (PH), CHIP, Community HealthChoices (CHC) MCOs, and the Adult Community Autism Program (ACAP) Prepaid Inpatient Health Plan (PIHP). ACAP is currently a small program, with 188 members enrolled as of September 2023, and EQR findings for this program are presented in a separate section within this report.

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

PH and BH HealthChoices Program

DHS's 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 PA 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.

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, Greene, Indiana, Lawrence, Washington, and Westmoreland counties; and

[1] prepaid inpatient health plan.
[2] prepaid ambulatory health plan.
[3] primary care case management.

- **Lehigh/Capital Zone** - Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties.

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

Starting in July 2006, the HealthChoices BH Program began statewide expansion on a zone phase-in schedule, incorporating additional zones to the original three listed above. The Northeast region's BH implementation went into effect in July 2006, followed by two North/Central implementations. Effective January 1, 2022, all 67 counties exercised their right of first opportunity to form contractual relationships for the HC BH Program. The current counties included in each of these zones are indicated below:

- **Northeast Zone** - Lackawanna, Luzerne, Susquehanna, and Wyoming counties;
- **North/Central Zone – County Option** - Bedford, Blair, Bradford, Cameron, Cambria, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Elk, Erie, Forest, Fulton, Franklin, Greene, Huntingdon, Jefferson, Juniata, Lycoming, McKean, Mifflin, Mercer, Monroe, Montour, Northumberland, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Tioga, Union, Venango, Warren, and Wayne counties.
- **North/Central State Option (BHARP) –** Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Greene, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne counties. Effective January 1, 2022, Greene County became a member county within the Behavioral Health Alliance of Rural Pennsylvania (BHARP), which had become the multi-county Primary Contractor for the other 23 counties in 2021.

All PA counties were covered by the HealthChoices PH Program in 2014, when it became mandatory statewide. For PH services in 2023, Medical Assistance enrollees had a choice of three to five PH-MCOs within their county (depending on the zone of residence).

The PH MCOs that were participating in the HealthChoices PH Program as of December 2023 were:

Physical Health MCOs

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

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

The BH-MCOs that were participating in the HealthChoices BH Program as of December 2023 were:

Behavioral Health MCOs

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

CHIP Program

PA'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, PA received approval from the federal government to expand eligibility for CHIP through the Cover All Kids initiative. As of March 2007:

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

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

The Affordable Care Act (the Patient Protection and Affordable Care Act, together with the Health Care and Education Reconciliation Act of 2010; ACA), signed into law in March 2010, provided additional changes for CHIP. The ACA extended federal funding of CHIP through September of 2015, as well as added a requirement that states maintain the Medical Assistance (MA) and CHIP eligibility standards, methods, and procedures in place on the date of passage of the ACA or refund the state's federal stimulus funds under The American Recovery and Reinvestment Act of 2009 (ARRA). In December 2015, Governor Tom Wolf signed Act 84 reauthorizing CHIP through 2017 and moving the administration of CHIP from the Insurance Department to DHS. As of July 1, 2018, the CHIP MCOs were required to comply with changes to the federal managed care regulations (*Title 42 CFR § 457* and *438*). CHIP continues to work with the CHIP MCOs to ensure organized and efficient implementation of these regulations. On January 22, 2018, the federal government passed a continuing resolution and adopted the Helping Ensure Access for Little Ones, Toddlers and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act). CHIP was authorized at the federal level, including funding appropriations through September 30, 2023. On February 9, 2018, Congress acted again to extend CHIP for an additional four years, or until September 30, 2027. CHIP is provided by the below private health insurance companies that are licensed and regulated by the Department of Human Services and have contracts with the Commonwealth to offer CHIP coverage. Approximately 180,000 children and teens were enrolled in PA CHIP as of February 2024.

CHIP-MCOs

- Aetna Better Health (ABH),
- Capital Blue Cross (CBC),
- Geisinger Health Plan (GEI),
- Highmark Healthy Kids (HHK)[4],
- Health Partners Plan (HPP),
- Independence Blue Cross (IBC),
- United Healthcare Community Plan (UHC), and
- UPMC for Kids (UPMC).

Community HealthChoices Program

The PA DHS Office of Long-Term Living (OLTL) oversees Community HealthChoices (CHC), which is PA's mandatory managed care program for LTSS. CHC is for adults aged 21 years and over, dually-eligible for Medicare and Medicaid, and for older adults, and adults with physical disabilities, in need of LTSS. LTSS includes services and supports in the nursing facility setting, as well as the home and community setting to

[4] As of July 1, 2022, Highmark HMO, Highmark PPO, and First Priority Health (NEPA) are reporting under the single entity, Highmark Healthy Kids.

help individuals perform daily activities in their home such as bathing, dressing, preparing meals, and administering medications. CHC aims to serve more people in communities, give them the opportunity to work, spend more time with their families, and experience an overall better quality of life. CHC was developed to improve and enhance medical care access and coordination, as well as create a person-centered LTSS system, in which people have a full array of quality services and supports that foster independence, health, and quality of life. CHC was being phased in over a three-year period: Phase 1 began January 1, 2018 in the Southwest region (Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties); Phase 2 began January 1, 2019, in the Southeast region (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties); and Phase 3 began January 1, 2020, in the remaining part of the state (Northeast [NE], Northwest [NW], and Lehigh Capital [L/C] Regions). Statewide, PA DHS OLTL contracts with CHC-MCOs to provide CHC benefits to members.

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

Community HealthChoices MCOs

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

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

ACP CHC/KF CHC are affiliated under a single, parent company, AmeriHealth Caritas. KF CHC is only responsible for the SE portion of the state, in which it was not implemented until 2019.

Office of Developmental Programs

The Office of Developmental Programs (ODP), through its Bureau of Support for Autism and Special Populations (BSASP), administers ACAP under the Adult Autism Waiver, a 1915(c) Home and Community-Based Services (HCBS) Medicaid waiver designed to provide long-term services and supports tailored to the specific needs of adults age 21 or older with Autism Spectrum Disorder (ASD). Under the waiver, DHS contracts through an agreement ("Agreement") with a PIHP to provide and pay for qualifying services to eligible adults with ASD living in Pennsylvania. As of this report, the PHIP currently operating in ACAP is Keystone Autism Services (KAS), a wholly owned subsidiary of Keystone Human Services, Inc. The Agreement subject to this report covers the Central Region counties of Chester, Cumberland, Dauphin, and Lancaster.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the four mandatory activities that were conducted. It should be noted that validation of network adequacy was conducted at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in January 2023. These updated protocols did state that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." As set forth in *Title 42 CFR § 438.358 Activities related to external quality review* (b)(1), these activities are:

(i) ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.

(ii) ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determined the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.

(iii) ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.

(iv) ***CMS Mandatory Protocol 4:* Validation of Network Adequacy –** This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid and CHIP populations. Starting February 2024, the EQRO must conduct validation activities and report those results in the annual technical report published in April 2025. While validation activities were not mandatory for MY 2022, PA identified initial reporting on network adequacy standards, indicators, and data collection processes as an opportunity to highlight their strengths and opportunities. Additionally, by engaging in initial validation activities, IPRO will be poised for a full set of validation activities in 2024.

(v) ***CMS Optional Protocol 6: Validation of Quality-of-Care Surveys*** – In 2023, satisfaction surveys were conducted to measure satisfaction with care received, providers, and health plan operations.

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

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

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

The *CMS External Quality Review (EQR) Protocols* published in February 2023 state that an Information Systems Capabilities Assessment (ISCA) is a required component of the mandatory EQR activities, and that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA[5]. Findings from IPRO's review of the MCO's HEDIS final audit report (FAR) are in **Section IV: Validation of Performance Measures**.

Information Sources

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

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

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

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

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

Note on Accessibility

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

[5] Centers for Medicare & Medicaid Services (CMS). (2023, February). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). 67. Department of Health & Human Services. CMS External Quality Review (EQR) Protocols (medicaid.gov)

II. PA Medicaid Managed Care and CHIP Program

PA Medicaid and CHIP Managed Care Quality Strategy

PA's current Managed Care Quality Strategy (MCQS) dated December 2023 was developed with input from stakeholders. The MCQS includes objectives, standards, and goals for the following overarching areas that impact health care services: network adequacy and availability; continuous quality improvement (QI); quality metrics and performance targets; performance improvement projects (PIPs); external independent reviews; Transitions of Care; health disparities; intermediate sanctions; LTSS; and non-duplication of EQR activities.[6]

The MCQS elucidates a high-level mission, "...to assist Pennsylvanians in achieving safe, healthy, and productive lives while being an accountable steward of Commonwealth resources"[6] as well as a set of guiding principles that drive a managed program that is person-centered, relationship-driven, community-based, data-driven, collaborative, innovative and equitable.

Goals and Objectives

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

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

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

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

- increasing value;
- supporting health equity;
- addressing social determinants of health (SDOH);[7,8] and
- ensuring beneficiaries receive the right care, in the right setting, at the right time.

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

Increase Access to Healthcare Services

- Access to physician services at academic medical centers
- Decrease emergency department utilization (EDU), inpatient admissions, and readmissions
- Maintain or increase access to inpatient hospital services
- Maintain or increase access to outpatient hospital services
- Increase initiation and engagement in drug dependence treatment by incentivizing follow-up after ED visit with opioid use disorder (OUD) diagnosis
- Increase access to care through use of Integrated Community Wellness Centers (ICWCs)
- Increase the percentage of members being served in their home or community
- Maintain or increase access to nursing facility services for medically necessary care
- Develop and implement educational programs and VBP initiatives for NF Services: in coordination with NF representatives, implement educational programs and VBP initiatives to improve care coordination and health and safety outcomes for NF participants
- Increase annual child and adult dental visits
- Increase lead screening
- Improve care for individuals with autism in the communities where they live, work, and are actively involved
- Ensure adequate, timely access to primary care
- Reduce racial disparities for African American members in select quality measures
- Preserve access to private duty nursing (PDN) services for members under the age of 21
- Preserve access to emergency services for members residing in and near the cities of Pittsburgh and Philadelphia

[6] PA DHS. (2023). *Medical Assistance and Children's Health Insurance Program managed care quality strategy*. 16-17. 2023 Medical Assistance Quality Assistance Strategy for Pennsylvania (pa.gov).

[7] SDOH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

[8] CDC. (2022). *Social determinants of health at CDC*. Social Determinants of Health at CDC | About | CDC.

- Increase contraceptive use in postpartum members
- Increase SDOH screenings and referrals specifically reported by the ICWCs

Improve the Health Outcomes of Populations

- Target Chronic Conditions
  - Controlling High Blood Pressure
  - Controlling HbA1c
- Improve utilization of key preventive services
  - Increase well child visits
  - Increase asthma medication ratios
  - Increase follow-up after ED visits
- Increase length of engagement in treatment for SUD through counseling and Medication-Assisted Treatment (MAT)
- Increase LTSS care planning
- Increase organizational cultural and linguistic capacity to reduce health disparities
- Improve equity and cultural competence of care provided to beneficiaries by acute care hospitals

Promote Efficient and Effective Use of Taxpayer Resources

- Support alternative payment models that promote quality of care while managing increasing costs
- Reduce the number of Potentially Avoidable Admissions
- Improve maternal health care by incentivizing high-quality care

IPRO's Assessment of the PA Managed Care Quality Strategy

Methodology of EQR Review of the MCQS

IPRO is employing the rubric from the CMS Medicaid and CHIP Managed Care: Quality Strategy Toolkit Summary, June 2021 in reviewing the Pennsylvania Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy dated December 2023.

CMS's vision of the EQR role in the evaluating the quality strategy is captured in **Figure 1**.

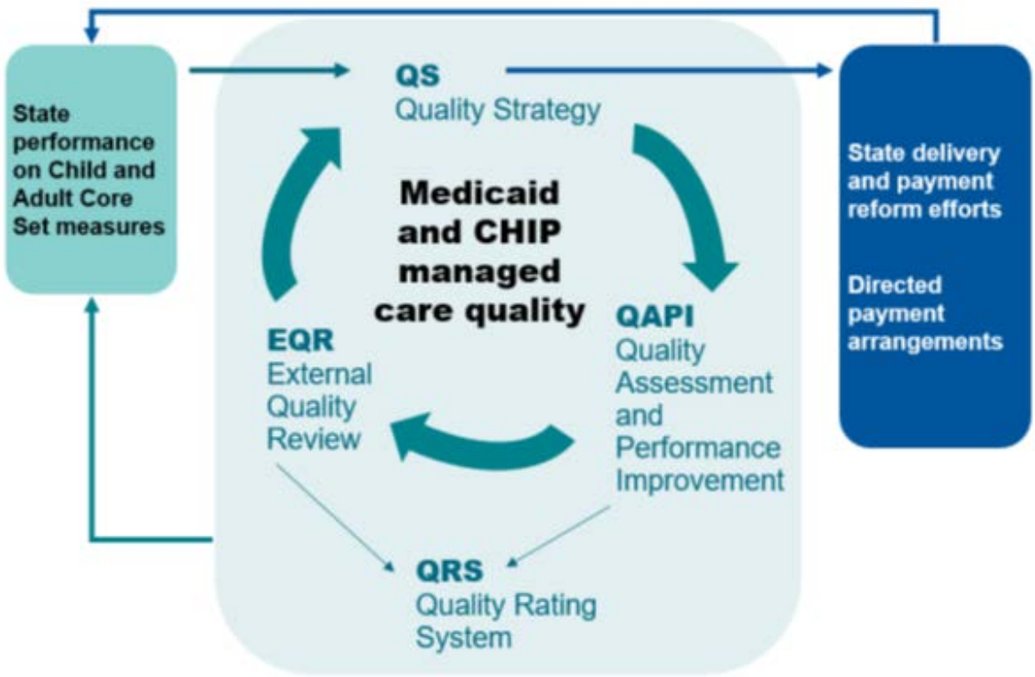

Figure 1: Relationship Between State Medicaid and CHIP Managed Care Quality Initiatives[9]

Observations

The structure of the programs for physical health, behavioral health, CHIP and LTSS/HCBS are all addressed in detail including the regional approach, the number, and types of plans.

DHS describes its process for seeking input from qualified stakeholders in developing its quality strategy. Stakeholders identified include: Medicaid members, the public, Medicaid Assistance Advisory Committee,

[9] Centers for Medicare & Medicaid Services. (2021). *Medicaid and Children's Health Insurance Program (CHIP) managed care quality strategy tool kit*. U. S. Department of Health and Human Services. Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy (medicaid.gov)

County Administrators Advisory Committee, Pennsylvania Mental Health Planning Council, Children's Health Advisory Council, LTSS Subcommittee, Information Sharing and Advisory Committee, and MCPs.

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

Monitoring

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

- Standard annual review of HEDIS measures across program offices
  - Compare results to goals
  - Root cause analysis on missed targets
  - Collaborative remediation planning, goal setting and re-evaluation with MCOs that miss targets
- Ongoing review of MCOs compliance with state and federal regulations
- DHS discusses its Medicaid Enterprise Monitoring Module (MEMM) dashboard, used for cross program aggregation of quality indicator monitoring. Among the core quality domains that are routinely monitored via MEMM are; Network Adequacy, Compliance, Performance Measures, Surveys, Care Management, and others.

Discussion of the Quality Management Program

The 2023 MCQS contains detailed descriptions of the PA statewide initiatives underway or under consideration for achieving the stated goals. Social Determinants of Health (SDOH)/health equity are targeted with increased detail in the new strategy document. DHS documents its engagement with stakeholders in developing their statewide SDOH strategy and provides details on activities completed and those being initiated.

There is a section dedicated to Value Based Payment and Pay-4-Performance (P4P) initiatives that are aligned with the goals of quality, access, and efficiency. These initiatives are also intended to increase the alignment between program offices. Specific topics with the goal structures of these programs include focuses on SDOH, maternity, post-partum and infant care, transitions of care, and integrated care for members with serious and persistent mental illness. All these programs are based on specific measurable indicators such as HEDIS or CAHPS. DHS also discusses potential future initiatives under consideration.

There is a section on PIPs with topics and timelines laid out by program office. There are high level descriptions of project aims and key interventions for each PIP. The report directs the reader to the EQR technical report on the DHS website for detailed results and analysis.

There is a section on Network Adequacy standards which includes details on time, distance, appointment availability all broken down by provider type, geographic region and DHS program office. This section also describes DHS' activities in monitoring compliance with these standards.

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

The MCQS delineates the provision that could trigger MCO sanctions and the possible sanctions or penalties that could be levied. The report contains a listing of MCO sanctions imposed within the past three years. There is a mention of five work plans that were implemented, the high-level topics of those plans, and a high-level mention of Corrective Action Plans (CAPs) relative to those topics. The narrative does not make clear the status, the metrics for completion, or the ongoing monitoring of those work plans and CAPs.

PA's quality management plan and execution is robust. In particular, the adoption of CMS core measures and an ambitious program to create quality dashboards through the MEMM project. Initiatives that target health equity, social determinants of health and health information are all forward looking and expansive. DHS is using the levers available through P4P programs to align quality and efficiency within the delivery systems.

Recommendations to PA DHS

The 2023 MCQS addresses several of the recommendations made in the 2023 technical report.

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

III. Validation of Performance Improvement Projects

Objectives

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

- measurement of performance using objective quality indicators,
- implementation of interventions to achieve improvement in access to and quality of care,
- evaluation of the effectiveness of interventions based on the performance measures, and
- planning and initiation of activities for increasing or sustaining improvement.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, PA contracted with IPRO to validate the PIPs that were underway in 2022. Specific MCO PIP topics are displayed in **Table 2**.

Table 2: PA DHS PIP Topics

Program Office	PIP Topic(s)[1]
OMAP	PIP 1: Preventing Inappropriate Use or Overuse of Opioids PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
CHIP	PIP 1: Improving Access to Pediatric Preventive Dental Care PIP 2: Improving Blood Lead Screening Rates in Children
OMHSAS	PIP 1: Prevention, Early Detection, Treatment, and Recovery for Substance Use Disorders
OLTL	PIP 1: Strengthening Care Coordination PIP 2: Transition of Care from the Nursing Facility to the Community

[1] Includes performance improvement projects (PIPs) that started, are ongoing, and/or were completed in the review year.
PIP: performance improvement project.

Technical Methods of Data Collection and Analysis

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

CMS's *Protocol 1. Validation of Performance Improvement Projects* was used as the framework to assess the quality of each PIP, as well as to score the compliance of each PIP with both federal and state requirements. IPRO's assessment involves the following 10 elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCO's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the MCO's enrollment and generalizable to the MCO's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the PIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the MCO achieved sustained improvement.

The first seven elements in the numbered list above relate to the baseline and demonstrable improvement phases of the project. The last three elements relate to sustaining improvement from the baseline measurement.

The 2023 EQR Protocols transitioned the validation process and reporting of PIP results from a compliance model to a confidence model. The evaluation consists of the review findings being considered to determine whether the PIP results should be accepted as valid and reliable. In accordance with the EQR PIP validation protocol issued by CMS in February 2023, IPRO adopted two qualitative assessments of the PIP, expressed in terms of levels of confidence (High, Moderate, and Low or None): 1) EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases; and 2) EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement. Additionally, compliance reporting was retained for PH, CHIP, and CHC

MCO PIP validation as the PIP cycles were progressing toward conclusion when the 2023 protocols went into effect. PIP compliance assessments will be phased out with the initiation of the next PIP cycle.

PIP Compliance Assessment

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points can be awarded for the two phases of the project noted above and combined to arrive at an overall score.

Table 3 presents the terminologies used in the scoring process, their respective definitions, and their weight.

Table 3: PIP Element Designation

Element Designation	Definition	Designation Weight
Met	Met or exceeded the element requirements	100%
Partially Met	Met essential requirements, but is deficient in some areas	50%
Not Met	Has not met the essential requirements of the element	0%

When the PIPs are reviewed, all projects are evaluated on the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. Untimely reporting by the MCO (i.e., if not in accordance with the submission schedule) may be factored into the overall determination. At the time each element is reviewed, a finding is given of "Met," "Partially Met," or "Not Met." Elements receiving a "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%.

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. As noted in **Table 4**, PIPs are also reviewed for the achievement of sustained improvement. Sustained improvement is assessed for the final year of a PIP, in this case, for MY 2022. The evaluation of the sustained improvement area has two review elements. These review elements have a total weight of 20%, for a possible maximum total of 20 points. To receive these points, the MCO must sustain improvement relative to baseline after achieving demonstrable improvement.

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

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

IPRO provided PIP report templates to each MCO for the submission of project proposals, interim updates, and results. All data needed to conduct the validations were obtained through these report submissions.

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Conclusions and Comparative Findings

The MCOs across all program offices sufficiently adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results to secure at least moderate confidence in the overall validity and reliability of the PIP methods and findings. The following section provides a summary of PIP reviews by DHS program office.

PH-MCO PIP Review

For the purposes of the EQR, PH-MCOs were required to participate in studies selected by OMAP for validation by IPRO in 2023 for 2022 activities. Under the applicable *HealthChoices Agreement* with the DHS in effect during this review period, Medicaid PH-MCOs are required to conduct focused studies each year. For all PH-MCOs, two PIPs were initiated as part of this requirement in 2021 and continued in 2023. For all PIPs, PH-MCOs are required to implement improvement actions and to conduct follow-up to demonstrate initial and sustained improvement or the need for further action.

As part of the EQR PIP cycle for all PH-MCOs in 2023, PH-MCOs were required to report on two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: "Preventing Inappropriate Use or Overuse of Opioids" and "Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits."

"Preventing Inappropriate Use or Overuse of Opioids" was selected because on average, 187 Americans die every day from opioid overdose.[10] In 2020, PA had the ninth highest rates among states for death due to drug overdose, at 42.4 per 100,000.[9] Considering this, governmental regulatory agencies have released multiple measures and societal recommendations to decrease the number of opioid prescriptions. PA DHS has sought to implement these measures as quickly as possible to impact its at-risk populations.

Because opioid misuse and abuse is a national crisis, and due to the impact this has had particularly on PA, the PIP is centered on opioids in the following four common outcome objectives: opioid prevention, harm reduction, coordination/facilitation into treatment, and increase medication-assisted treatment (MAT) utilization.

"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits" was selected because avoidable emergency department (ED) utilization rates, preventable hospitalization, and rehospitalization within 30 days can be seen as indicators of the quality and efficiency of the healthcare system (ambulatory care and inpatient care) as well as patients' adoption of healthy lifestyle and active self-management of chronic conditions.[11]

Populations at greater risk of avoidable ED visits, hospitalization, and readmission include individuals living with challenges to the social determinants of health (SDOH) and people diagnosed with serious persistent mental illness (SPMI).[12,13] In 2016, PA implemented the PH-MCO and BH-MCO Integrated Care Plan (ICP) Program Pay for Performance Program to address the needs of individuals with SPMI through person-centered care planning, advance discharge planning, and medication management.

Because interventions by MCOs are needed to improve patient care and reduce hospital cost, the PIP had the following outcome objectives: leverage care coordination and integration of services to reduce the rate of ambulatory-sensitive ED visits, preventable hospitalizations, and 30-day readmissions, focusing on populations at greatest risk to address healthcare disparities.

To encourage MCOs to focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the PH-MCOs, and IPRO continued and progressed throughout the review year. **Tables 5** and **7** summarize PIP compliance assessments across PH-MCOs. **Tables 6** and **8** summarize the confidence ratings of the PIP projects, by MCO, based on review of the MCO PIP reports. A list of PH-MCO PIP interventions, as reported by the PH-MCOs in their annual PIP reports, is in **Table A1** of **Appendix A**.

Table 5: PH-MCO PIP Review Score – Preventing Inappropriate Use or Overuse of Opioids

Project 1 - Preventing Inappropriate Use or Overuse of Opioids	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic	P	P	C	C	C	C	C	P

[10] Centers for Disease Control and Prevention (CDC). *2020 drug overdose death rates | Drug overdose | CDC Injury Center*. 2020 Drug Overdose Death Rates | Drug Overdose | CDC Injury Center.

[11] Agency for Healthcare Research and Quality (AHRQ). *Preventable emergency department visits*. Preventable Emergency Department Visits | Agency for Healthcare Research and Quality (ahrq.gov).

[12] Peters, Z. J., Santo, L., Davis, D., & DeFrances, C. J. (2023). Emergency Department Visits Related to Mental Health Disorders Among Adults, by Race and Hispanic Ethnicity: United States, 2018–2020. *National health statistics reports*, (181), 1–9. https://dx.doi. org/10.15620/cdc:123507.

[13] Penzenstadler, L., Gentil, L., Grenier, G., Khazaal, Y., & Fleury, M. J. (2020). Risk factors of hospitalization for any medical condition among patients with prior emergency department visits for mental health conditions. *BMC psychiatry*, *20*(1), 431. https://doi.org/10.1186/s12888-020-02835-2.

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

Table 6: EQR Confidence Ratings in PH-MCO Preventing Inappropriate Use or Overuse of Opioids PIP Results

PH-MCOs	Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases	Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
ACP	Moderate confidence	Low confidence
GEI	Moderate confidence	Low confidence
HPP	High confidence	Moderate confidence
HWC	Moderate confidence	Moderate confidence
KF	Moderate confidence	Low confidence
UHC	Moderate confidence	Moderate confidence
UPMC	High confidence	Moderate confidence

Table 7: 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	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic	P	P	C	C	P	C	C	P
2. Methodology	P	P	C	C	P	P	C	P
3. Barrier Analysis, Interventions, and Monitoring	P	P	C	P	P	P	C	P
4. Results	P	P	C	C	C	C	P	P
5. Discussion	P	P	C	C	P	C	P	P
6. Next Steps	P	C	C	C	C	C	C	P
7. Validity and Reliability of PIP Results	P	P	C	C	P	C	P	P

Table 8: EQR Confidence Ratings in PH-MCO Reducing Potentially Preventable Hospital Admissions, Readmissions, and ED Visits PIP Results

PH-MCOs	Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases	Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
ACP	Moderate confidence	Low confidence
GEI	Moderate confidence	Low confidence
HPP	High confidence	High confidence
HWC	Moderate confidence	Low confidence
KF	Moderate confidence	Low confidence
UHC	Moderate confidence	Moderate confidence
UPMC	Moderate confidence	Low confidence

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 2023 for 2022 activities. Under the applicable Agreement with DHS in effect during this review period, CHIP MCOs are required to conduct focused studies each year. For all CHIP MCOs, two new PIPs were initiated as part of this requirement in 2021. For all PIPs, CHIP MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the EQR PIP cycle that was initiated for all CHIP MCOs in 2021, CHIP MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, the two topics selected were "Improving Access to Pediatric Preventive Dental Care" and "Improving Blood Lead Screening Rate in Children."

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

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

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

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

"Improving Blood Lead Screening Rates in Children" was the PIP topic from 2017 to 2021 and repeated for the current cycle beginning in 2021 due to several factors. A 2021 look at national trends regarding lead screening and blood lead levels (BLLs) showed that PA was among the states with the highest number of children with elevated BLLs, with most samples coming from the Philadelphia and Pittsburgh metropolitan areas. The National Surveillance Data table, utilizing National Health and Nutrition Examination Survey (NHANES) data, supported this finding, citing percentages ranging from 6%−9% for children with BLLs at least 5 ug/dL and around 1.5% for children with at least 10 ug/dL in PA. Current CHIP policy requires that all children ages 1−2 years and all children ages 3−6 years without a prior lead blood test have blood levels screened consistent with current Department of Health (DOH) and Centers for Disease Control and Prevention (CDC) standards. Between 2012 and 2018, PA has seen fluctuating lead screening rates for children younger than 72 months old, with 17.8% screened in both 2012 and again in 2018. Using the HEDIS Lead Screening measure, the average national lead screening rate in 2019 was 70.0%, while the PA CHIP average was 66.2%. This rate fell between the 25th and 33rd percentile for HEDIS Quality Compass® benchmarks. Despite an overall improvement in lead screening rates for PA CHIP contractors over the previous few years, rates by MCO and weighted average continued to be below the national average. Additionally, when comparing PA Medicaid and CHIP rates, Medicaid's weighted average rate for 2019 was 81.6%, 15.5 points higher than CHIP. However, regarding population, it was noted that children younger than 1 year of age typically receive Medicaid benefits until they reach 1 year of age. At this point, many children move over to CHIP, provided their families are eligible. MCOs were advised that this can affect overall CHIP rates across all MCOs, since the < 1 year age group will have disproportionately fewer members than older age groups.

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

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

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

The PIPs extend from January 2021 through December 2024. The non-intervention baseline period is January 2021 to December 2021, with research beginning in 2022. Initial PIP proposals were developed and submitted in first quarter 2022, and baseline reports including any proposal updates were submitted by MCOs in August 2022. Following the formal PIP proposal and baseline measurement reports, the timeline defined for the PIPs includes an interim report in 2023, as well as a final report in August 2024.

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

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

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

To encourage MCOs to focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the CHIP MCOs, and IPRO continued and progressed throughout the review year. **Tables 9** and **11** summarize PIP compliance assessments across CHIP-MCOs. **Tables 10** and **12** summarize the confidence ratings of the PIP projects, by MCO, based on review of the MCO PIP reports. A list of CHIP-MCO PIP interventions, as reported by the MCOs in their annual PIP reports, is in **Table A2** of **Appendix A**.

Table 9: CHIP-MCO PIP Review Score – Improving Access to Pediatric Preventive Dental Care

Project 1 - Improving Access to Pediatric Preventive Dental Care	ABH	CBC	GEI	HPP	HHK	IBC	UHC	UPMC	TOTAL CHIP MMC
1. Project Topic and Rationale	C	C	C	C	C	C	C	C	C
2. Aim Statement	C	C	C	C	C	C	C	C	C
3. Methodology	C	P	C	C	C	C	C	C	P
4. Barrier Analysis	C	P	P	C	C	C	C	C	P
5. Robust Interventions	C	P	P	C	C	C	C	C	P
6. Results Table	C	C	C	P	C	C	C	C	P
7. Discussion and Validity of Reported Improvement	C	C	C	C	C	C	C	C	C

Table 10: EQR Confidence Ratings in CHIP-MCO Improving Access to Pediatric Preventative Dental Care PIP Results

CHIP-MCOs	Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases	Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
ABH	High confidence	Moderate confidence
CBC	Moderate confidence	Low confidence
GEI	Moderate confidence	Moderate confidence
HPP	High confidence	Moderate confidence
HHK	High confidence	High confidence
IBC	High confidence	High confidence
UHC	High confidence	Moderate confidence
UPMC	High confidence	Moderate confidence

Table 11: CHIP-MCO PIP Review Score – Improving Blood Lead Screening Rates in Children

Project 2 - Improving Blood Lead Screening Rates in Children	ABH	CBC	GEI	HPP	HHK	IBC	UHC	UPMC	TOTAL CHIP MMC
1. Project Topic and Rationale	C	C	C	C	C	C	C	C	C
2. Aim Statement	C	C	C	C	C	C	C	C	C

Project 2 - Improving Blood Lead Screening Rates in Children	ABH	CBC	GEI	HPP	HHK	IBC	UHC	UPMC	TOTAL CHIP MMC
3. Methodology	C	P	P	C	C	C	C	C	P
4. Barrier Analysis	C	P	P	C	C	P	P	C	P
5. Robust Interventions	C	P	P	C	C	C	C	C	P
6. Results Table	C	C	P	C	C	C	C	C	P
7. Discussion and Validity of Reported Improvement	C	C	P	C	C	C	C	C	P

Table 12: EQR Confidence Ratings in CHIP-MCO Improving Blood Lead Screening Rates in Children PIP Results

CHIP-MCOs	Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases	Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
ABH	High confidence	Moderate confidence
CBC	Moderate confidence	Low confidence
GEI	Moderate confidence	Low confidence
HPP	High confidence	Moderate confidence
HHK	High confidence	High confidence
IBC	Moderate confidence	Moderate confidence
UHC	Moderate confidence	Moderate confidence
UPMC	High confidence	Moderate confidence

BH-MCO PIP Review

In accordance with current BBA regulations, IPRO validates at least one PIP for the MCO. The Primary Contractors and 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.

The name of the current PIP project is "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders" (SUD). The Aim Statement for this PIP reads: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

The PIP has three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an opioid use disorder (OUD) and/or other SUD;
2. Improve retention in treatment for members with an OUD and/or other SUD diagnosis;
3. Increase concurrent use of drug and alcohol counseling in conjunction with pharmacotherapy (medication-assisted treatment [MAT]); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH contracting networks. The two "activities" may fall under a single intervention or may compose two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

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

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[14] It contains two submeasures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary

[14] National Committee for Quality Assurance (NCQA). (2020). *HEDIS® volume 2: Technical specifications for health plans.* NCQA. https://store.ncqa.org/hedis-2020-volume-2-epub.html.

diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure measures discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" will include detox episodes only.

3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary MH diagnosis occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.
4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services and pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[15] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe alcohol use disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

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

The evaluation consists of the review findings being considered to determine whether the PIP results should be accepted as valid and reliable. In accordance with the EQR PIP validation protocol issued by CMS in February 2023, BH replaced the former scoring with two qualitative assessments of the PIP, expressed in terms of levels of confidence (High, Moderate, and Low or None): 1) EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases; and 2) EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement.

This PIP project will extend from January 2021 through December 2024, including a one-year extension, with initial PIP proposals submitted in 2020 and a final report due in September 2025. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline. **Table 13** summarizes the confidence ratings of the PIP projects, by MCO, based on review of the Year 3 (MY 2022) reports.

Table 13: EQR Confidence Ratings in BH-MCO PIP Results

BH-MCOs	Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases	Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
Carelon	Moderate	Moderate
CBH	Moderate	Moderate
CCBH	High	Moderate
MBH	Moderate	Moderate
PerformCare	Moderate	Moderate

EQR: external quality review; PIP: performance improvement project; MCO: managed care organization; EQRO: external quality review organization.

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls is to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as

[15] National Quality Forum (NQF). (2020, August 12). 3400: Use of pharmacotherapy for opioid use disorder (OUD). *Quality positioning system (QPS) measure description display information. http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=3400&print=0&entityTypeID=1.*

necessary. MCOs will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, instead of two semiannual submissions, MCOs submit only one PIP interim report each September, when formal scoring is rendered.

CHC-MCO PIP Review

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO. In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each CHC-MCO.

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

For each PIP, there was a set of baseline implementations that were region dependent with related region dependent timelines, until full rollout across all regions was completed. To introduce each PIP cycle, DHS CHC provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions, and timeliness. For all PIPs, CHC-MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

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

“Strengthening Care Coordination” was selected as a topic following discussions with stakeholders and in collaboration with the EQRO. Each CHC-MCO was required to implement interventions and indicate performance on the topic of strengthening care coordination with assessment and improvement of outcomes of care rendered by the CHC-MCO. Between 2018 and 2020, CHC-MCOs submitted proposals for PIP expansion in sequence with CHC being phased in. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly. Subsequent to each proposal submission, baseline data in proposals was then updated as supplemental data became available. For this PIP, CHC-MCOs were required to submit rates at the baseline and interim measurement years for transitions of care measures aligned with clinical care coordination, with indicators for notification of inpatient admission, receipt of discharge note, engagement after inpatient discharge, as well as a hospitalization follow-up indicator for seven-day follow up behavioral discharge. Additionally, indicators aligned with capabilities of information systems were developed and implemented to encompass transitional care planning and adjustments to improved notification of discharge.

“Transition of Care from the NF to the Community” was selected following discussions with stakeholders and in collaboration with the EQRO. Each CHC-MCO was required to implement interventions and indicate performance on the topic of transition of care from the nursing facility to the community, entailing assessment and improvement of outcomes of care rendered by the MCO. Between 2018 and 2020, CHC-MCOs submitted proposals for PIP expansion in sequence with CHC being phased in. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly. Subsequent to each proposal submission, baseline data in proposals was then updated as supplemental data became available. For this PIP, CHC-MCOs were required to submit rates at the baseline and interim measurement years for transitions of care measures, with indicators for receipt of discharge note, engagement after inpatient discharge, and medication reconciliation, and an indicator for participants remaining in home or community-based setting, at least six months post-discharge. Additionally, an indicator aligned with capabilities of information systems was developed and implemented to encompass transitional care planning.

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

- Activity Selection and Methodology
- Data/Results

- Analysis Cycle
- Interventions

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

Overall Performance Score

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

As also noted in **Table 4** (Scoring Matrix), PIPs are also reviewed for the achievement of sustained improvement. For the EQR of CHC-MCO PIPs, sustained improvement elements have a total weight of 20%, for a possible maximum total of 20 points. The MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation by IPRO will occur at the end of the current PIP cycle. In 2022, a determination for Element #8 (Sustainability) is not yet applicable based on the phase of CHC PIP implementation.

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

PIP activities during the year included updating PIP performance indicator (PI) goals, baseline rates, barrier analyses, and development and implementation of interventions as well as additional PIs. For measurement in the PIP, multiple data sources were allowable, including: MCO pharmacies, service coordinator entities, copayments (i.e., after day 20 for Medicare-covered skilled nursing stays), and traditional long-term care claims. Preliminary measurements were based on participants that were Medicaid-only CHC participants and/or aligned Dual Special Needs Plan (D-SNP) CHC participants; as PIP implementation expanded, CHC-MCOs utilized internal claims while the supplemental data source integration was scaled accordingly. Baseline rates were recalculated (and integrated into the PIP) with improved access to data. Annual PIP reports on Year 4 Implementation, which were subjected to EQR and scored for reporting the year's PIP compliance determinations, were submitted to the EQRO in March 2023 with updates on interventions through the first half of 2023 due to the EQRO in July 2023.

Tables 14 and **15** summarize PIP compliance assessments across CHC-MCOs for Annual PIP Reports (Year 4 Implementation) review findings. The multiple levels of activity and collaboration between DHS, the CHC-MCOs, and IPRO continued and progressed throughout the review year. **Table 16** summarizes the confidence ratings of the PIP projects, by MCO, based on review of the Year 4 (MY 2022) reports.

Table 14: CHC-MCO PIP Review Score – Strengthening Care Coordination

Project 1 - Strengthening Care Coordination	ACP CHC	KF CHC	PHW	UPMC CHC	TOTAL CHC MMC
1. Project Topic and Rationale	C	C	C	C	C
2. Aim Statement	C	C	C	C	C
3. Methodology	C	C	C	C	C
4. Barrier Analysis	C	C	C	C	C
5. Robust Interventions	C	C	C	C	C
6. Results Table	C	C	C	C	C

Project 1 - Strengthening Care Coordination	ACP CHC	KF CHC	PHW	UPMC CHC	TOTAL CHC MMC
7. Discussion	C	C	C	C	C
8. Sustainability	N/A	N/A	N/A	N/A	N/A

Table 15: CHC-MCO PIP Review Score – Transition of Care from the NF to the Community

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

Further evaluation consists of the review findings being considered to determine whether the PIP results should be accepted as valid and reliable. In accordance with the EQR PIP validation protocol issued by CMS in February 2023, the level of overall confidence in the CHC-PIPs are provided.

Table 16: CHC-MCO PIP Validation Rating - Overall Confidence

PIP Validation Rating	ACP CHC	KF CHC	PHW	UPMC CHC
Strengthening Care Coordination	High	High	High	High
Transition of Care from the NF to the Community	High	High	High	High

The compliance determinations for elements of Project Topic and Rationale, Aim Statement, Methodology, Barrier Analysis, Results Table, and Discussion were sufficiently met for both PIP topics. For each CHC-MCOs' two PIPs, all scores based on the element determinations exceeded ≥ 85%. Based on the element determinations, the validation for the Strengthening Care Coordination PIP and Transition of Care from the NF to the Community PIP for each of the CHC-MCOs was determined to be of high confidence.

IV. Validation of Performance Measures

Objectives

PA selects quality metrics and performance targets by assessing gaps in care within the state's Medicaid and CHIP population. DHS monitors and uses data that evaluates the MCOs' strengths and opportunities for improvement in serving the Medicaid and CHIP population by specifying performance measures. The selected performance measures and performance targets are reasonable, based on industry standards, and consistent with the CMS's *External Quality Review (EQR) Protocols*. The MCOs are required to follow NCQA HEDIS, CMS Adult and Child Core Set, and Pennsylvania Performance Measure (PAPM) technical specifications for reporting, as determined by each DHS program office. DHS conducts annual monitoring of the performance measures to observe trends and to identify potential risks to meeting performance targets. Annually, the EQRO validates the MCOs' reported performance rates.

Pennsylvania Performance Measures

MCOs collect PAPMs, "which are a set of state quality measures that were developed focusing on specific areas of importance to the Commonwealth that are not captured through other available data sets. PAPMs use statistically valid methodologies and allow program offices to track program performance over time. MCOs are required to report specific data for measures according to the requirements of the managed care program(s) in which they participate, and the most current year's measures selected. Data sources include, but are not limited to, encounter data, participant interviews, patient experience surveys, on-site documents, electronic file reviews, quarterly, and annual reports."[16]

CMS Core Set Measures

The CMS measures are known as Core Set measures and are indicated below for children and adults. For each indicator, the eligible population is identified by product line, age, enrollment, anchor date, and event/diagnosis. Administrative numerator positives are identified by date of service, diagnosis/procedure code criteria, and other specifications as needed.

HEDIS Health Plan Measures

The NCQA is the steward of over 90 quality measures across six domains of care, including:

- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.
- Health Plan Descriptive Information.
- Measures Reported Using Electronic Clinical Data Systems[17]

"HEDIS is the nation's most widely used set of health care performance measures." [18] HEDIS is a performance improvement tool and HEDIS data are used to set benchmarks and performance standards.

MY 2022 was the first year MCOs reported HEDIS Health Plan measures from the electronic clinical data systems domain. Electronic clinical data systems (ECDS) capture care that aligns with evidence-based practices and promote health information portability, leading to improvements in healthcare quality and timeliness. ECDS measures are calculated using electronic clinical data.

Additionally, NCQA added race and ethnicity stratification reporting guidelines for MY 2022 for the following measures:

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients With Diabetes
- Prenatal and Postpartum Care
- Child and Adolescent Well-Care Visits

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. The race reporting categories are White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian and other Pacific Islander, some other race, two or more races, asked but no answer, and unknown. The ethnicity categories are Hispanic/Latino, not Hispanic/Latino, asked but no answer, unknown, and total (total of all categories).

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[16] PA DHS. (2023). *Medical Assistance and Children's Health Insurance Program managed care quality strategy*. 40. 2023 Medical Assistance Quality Assistance Strategy for Pennsylvania (pa.gov).
[17] NCQA. *HEDIS and performance measurement.* NCQA | HEDIS (ncqa.org)
[18] NCQA. *HEDIS data submission*. NCQA | HEDIS Data Submission (ncqa.org)

PH-MCO Performance Measures

PH-MCOs were required to report measures under the PAPM, CMS Core Set, and HEDIS categories. Validation activities specific to PH-MCO performance measures are described in the following sections.

PH-MCO PAPM Validation

For MY 2022, these performance measure rates were calculated through one of two methods: 1) administrative, which uses only the MCO's data systems to identify numerator positives; and 2) hybrid, which uses a combination of administrative data and medical record review (MRR) to identify numerator "hits" for rate calculation.

PH-MCO Core Set Measures Validation

A number of performance measures require the inclusion of PH and BH services. Due to the separation of PH and BH services for Medicaid, DHS requested that IPRO use encounters submitted by all PH- and BH-MCOs to DHS via the PROMIS*e* encounter data system to ensure both types of services were included, as necessary. For some measures, IPRO enhanced PH data submitted by MCOs with BH PROMIS*e* encounter data, while for other measures, IPRO calculated the measures using PROMIS*e* encounter data for both the BH and PH data required.

PH-MCO HEDIS Measures Validation

Each PH-MCO underwent a full HEDIS Compliance Audit in 2023. The PH-MCOs are required by DHS, as part of their Quality Assessment and Performance Improvement (QAPI) programs, to report the complete set of Medicaid measures, as specified in the *HEDIS MY 2022: Volume 2: Technical Specifications*.

Each year, DHS updates its requirements for the MCOs to be consistent with NCQA's requirement for the reporting year. MCOs are required to report the complete set of Medicaid measures except for measures requiring exclusively a BH benefit (BH being carved out in PA), the LTSS measures, and the survey measures.

PH-MCOs were required to report race and ethnicity stratifications for the five measures identified by NCQA for MY 2022. Race and ethnicity stratifications are reported in **Table 26**.

Consumer Assessment of Healthcare Providers and Systems Survey

The CAHPS program includes many products designed to capture consumer and patient perspectives on health care quality. Survey sample frame validation is conducted by NCQA-certified auditors for the Adult and Child Medicaid CAHPS.

For the Adult and Child Medicaid CAHPS, all CHC-MCOs' survey sample frames were deemed valid by the NCQA-certified auditor. The CAHPS program includes many products designed to capture consumer and patient perspectives on health care quality. Survey sample frame validation is conducted by NCQA-certified auditors for the Adult and Child Medicaid CAHPS.

For the Adult and Child Medicaid CAHPS, all PH-MCOs' survey sample frames were deemed valid by the NCQA-certified auditor. PH-MCO survey results are presented in **Tables 74** and **75** in **Section VII: Validation of Quality-of-Care Surveys.**

PH-MCO Conclusions and Comparative Findings

The MCOs successfully completed the HEDIS audit. The MCOs received an audit designation of report for all applicable measures. Additionally, the MCOs successfully implemented all PAPM and Core Set measures for MY 2022 that were reported with MCO-submitted data. The MCOs submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCOs. All rates submitted by the MCOs were reportable.

Tables 17–28 represent the aggregated performance measure data for all seven PH-MCOs in 2023, as well as the PA mean and the PH MMC weighted average, which takes into account the proportional relevance of each MCO. The aggregated data includes combined stratifications and total age groups, as applicable. If the denominator was less than 30 for a particular rate, "N/A" (Not Applicable) appears in the corresponding cells. Additionally, each table reports improvement or decline in the weighted average from the previous year. Comparisons to fee-for-service Medicaid data are not included in this report as the fee-for-service data and processes were not subject to a HEDIS compliance audit for HEDIS MY 2022 measures.

The individual MCO MY 2022 EQR reports present a subset of these measures that include the complete measure stratification and age group breakouts. Additionally, the individual PH-MCO reports include:

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

- Comparisons to the MCO's previous year rate and to the MMC rate.

Access to/Availability of Care

Table 17 is the full set of aggregated data for MY 2022 access to/availability of care measures validated for OMAP.

Table 17: PH-MCO Access to/Availability of Care Performance Measures

PH-MCO Access to/Availability of Care Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 21 years and older)	28.3%	25.9%	25.9%	26.5%	29.5%	22.9%	28.3%	26.8%	27.5%	Improved
Adult Annual Dental Visit: Women with a Live Birth (Ages 21 to 59 years)	31.7%	33.5%	33.2%	30.5%	31.9%	23.3%	36.5%	31.5%	32.3%	Improved
Adults' Access to Preventive/Ambulatory Health Services (Total)	81.2%	82.0%	68.6%	78.3%	72.5%	64.6%	83.8%	75.8%	77.4%	Declined
Annual Dental Visit (Total)	61.3%	65.4%	57.7%	63.9%	67.2%	75.3%	59.7%	64.4%	63.2%	Improved
Annual Dental Visits for Members with Developmental Disabilities	63.4%	66.8%	59.5%	65.7%	69.1%	71.0%	61.6%	65.3%	64.7%	Improved
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Total) [1]	42.4%	43.2%	41.9%	41.1%	41.0%	43.6%	39.0%	41.7%	41.3%	-
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Total) [1]	45.6%	47.3%	45.4%	45.2%	47.2%	42.8%	46.3%	45.7%	45.9%	-
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Total) [1]	42.9%	47.1%	42.4%	43.2%	46.7%	45.5%	43.2%	38.3%	44.3%	-
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Total) [1]	41.9%	44.4%	41.3%	41.6%	43.2%	42.4%	41.4%	42.3%	42.2%	-
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Total) [1]	21.6%	22.8%	16.6%	19.8%	16.1%	20.1%	19.8%	19.5%	19.5%	-
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Total) [1]	31.4%	34.8%	28.7%	31.2%	28.5%	27.6%	32.9%	30.7%	30.8%	-
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Total) [1]	22.6%	25.8%	17.3%	22.7%	20.3%	21.8%	23.3%	22.0%	21.9%	-
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Total) [1]	23.4%	25.9%	19.2%	23.1%	20.3%	21.8%	23.9%	22.5%	22.5%	-
Prenatal and Postpartum Care - Timeliness of Prenatal Care	90.5%	88.8%	87.6%	88.1%	87.1%	89.1%	90.0%	88.7%	88.7%	Declined
Prenatal and Postpartum Care - Postpartum Care	85.4%	79.6%	79.6%	78.1%	81.5%	80.1%	83.9%	81.2%	81.6%	Improved
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	65.3%	62.2%	63.0%	65.9%	56.9%	61.6%	61.6%	62.4%	62.3%	Declined

[1]The specification underwent severe changes in MY 2022. A year-to-year comparison is not applicable during this transition period. MY: measurement year; MMC: Medicaid Managed Care.

Behavioral Health

Table 18 is the full set of aggregated data for MY 2022 behavioral health measures validated for OMAP.

Table 18: PH-MCO Behavioral Health Performance Measures

PH-MCO Behavioral Health Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Adherence to Antipsychotic Medications for Individuals With Schizophrenia - BH Enhanced[1]	70.3%	69.2%	62.0%	74.5%	69.7%	65.9%	78.1%	70.0%	71.8%	Improved
Antidepressant Medication Management - Effective Acute Phase Treatment	64.1%	64.6%	54.9%	59.9%	60.1%	57.8%	65.9%	61.1%	62.2%	Improved
Antidepressant Medication Management - Effective Continuation Phase Treatment	47.1%	45.3%	37.3%	40.6%	43.7%	40.1%	48.5%	43.2%	44.5%	Improved
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	N/A	N/A	N/A	N/A	90.7%	N/A	78.3%	84.5%	81.6%	Improved
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (>9.0%) (Total)	83.8%	90.1%	83.2%	68.2%	93.7%	95.7%	75.2%	84.3%	81.5%	Improved
Diabetes Monitoring for People With Diabetes and Schizophrenia	71.8%	78.5%	75.4%	74.1%	74.3%	70.1%	79.0%	74.7%	76.0%	Improved
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.7%	88.8%	76.2%	86.6%	84.7%	85.7%	87.3%	85.3%	86.0%	Declined
Diagnosed Mental Health Disorders (Total)[2]	33.0%	34.2%	23.3%	33.7%	25.0%	22.1%	39.7%	30.2%	31.4%	-
Diagnosed Substance Use Disorders - Alcohol (Total)[3]	1.8%	1.9%	1.6%	2.2%	1.7%	2.1%	3.0%	2.0%	2.1%	-
Diagnosed Substance Use Disorders - Any (Total)[3]	5.1%	6.4%	4.8%	6.3%	5.6%	6.3%	9.3%	6.3%	6.5%	-
Diagnosed Substance Use Disorders - Opioid (Total)[3]	2.4%	4.0%	2.0%	3.3%	2.9%	3.1%	5.4%	3.3%	3.5%	-
Diagnosed Substance Use Disorders - Other (Total)[3]	2.1%	2.3%	2.6%	2.5%	2.7%	3.3%	3.6%	2.7%	2.8%	-
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)[4]	43.6%	52.7%	38.8%	46.9%	35.1%	39.1%	41.7%	42.6%	43.0%	-
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)[4]	60.4%	68.1%	49.3%	61.1%	48.3%	52.2%	58.9%	57.0%	58.2%	-
Follow-Up After Emergency Department Visit for Substance Use – 7 days (Total)[5]	32.6%	34.9%	37.2%	33.6%	35.9%	31.0%	33.7%	34.1%	34.2%	-
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)[5]	47.4%	50.7%	49.5%	49.2%	50.3%	46.2%	48.8%	48.9%	48.9%	-
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase - BH Enhanced[1]	45.4%	42.5%	55.3%	43.5%	32.8%	40.8%	51.5%	44.5%	44.5%	Improved
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - BH Enhanced[1]	53.0%	47.7%	63.6%	52.7%	44.0%	43.8%	59.3%	52.0%	52.5%	Improved
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	79.2%	83.4%	54.1%	80.0%	72.9%	71.4%	79.2%	74.3%	78.0%	Improved
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	69.1%	75.2%	60.3%	72.9%	64.1%	61.7%	68.3%	67.4%	69.2%	Improved

PH-MCO Behavioral Health Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	67.5%	74.1%	48.2%	70.3%	60.7%	60.9%	67.1%	64.1%	66.9%	Improved
Pharmacotherapy for Opioid Use Disorder (Total)	25.9%	28.9%	20.0%	19.9%	23.6%	19.2%	20.7%	22.6%	22.3%	Improved
Screening for Depression and Follow-Up Plan (Total)[6]	2.5%	3.5%	1.2%	10.1%	0.6%	4.6%	11.1%	4.8%	4.9%	-
Use of Pharmacotherapy for Opioid Use Disorder: Any Medication	76.3%	75.0%	69.6%	77.7%	69.8%	65.5%	78.9%	73.3%	76.2%	Declined

[1] BH-enhanced: Measures based on physical health MCO HEDIS submissions and enhanced with data from BH-MCOs. To validate the measure, MCOs submit member level data files that match the MCO's HEDIS IDSS, IPRO validates the data files to ensure the appropriate information is received, and IPRO enhances the denominator and numerator values based on BH PROMIS*e* encounters.
[2]The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.
[3]The measure provides information on the diagnosed prevalence of substance use disorders. Neither a higher nor lower rate indicates better performance.
[4]The youngest age group expanded from ages 13-17 years in MY 2021 to ages 6-17 years in MY 2022. A year-to-year comparison is not applicable during this transition.
[5]The specification underwent severe changes in MY 2022. A year-to-year comparison is not applicable during this transition period.
[6]The measure was first reported for MY 2022. A year-to-year comparison is not applicable.
MY: measurement year; MMC: Medicaid Managed Care; N/A: not applicable, the denominator was less than 30.

Cardiovascular Conditions

Table 19 is the full set of aggregated data for MY 2022 cardiovascular conditions measures validated for OMAP.

Table 19: PH-MCO Cardiovascular Conditions Performance Measures

PH-MCO Cardiovascular Conditions Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Cardiac Rehabilitation - Initiation (Total)	7.0%	3.2%	1.8%	1.5%	1.9%	2.3%	2.7%	2.9%	2.9%	Improved
Cardiac Rehabilitation - Engagement1 (Total)	8.8%	5.2%	1.2%	0.0%	2.8%	4.3%	5.2%	3.9%	4.2%	Improved
Cardiac Rehabilitation - Engagement2 (Total)	6.8%	5.2%	1.5%	0.0%	2.8%	4.6%	4.8%	3.7%	3.9%	Improved
Cardiac Rehabilitation - Achievement (Total)	1.8%	1.2%	0.0%	0.0%	0.4%	2.0%	2.4%	1.1%	1.3%	Improved
Controlling High Blood Pressure	74.5%	71.1%	61.6%	73.2%	65.9%	63.5%	74.0%	69.1%	70.3%	Improved
Persistence of Beta-Blocker Treatment After a Heart Attack	91.2%	83.7%	77.7%	81.5%	83.3%	81.5%	89.7%	84.1%	85.3%	Declined
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	85.0%	85.9%	84.0%	83.9%	82.4%	80.7%	84.6%	83.8%	84.2%	Declined
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	78.4%	78.6%	73.6%	75.5%	78.6%	71.3%	80.7%	76.7%	78.4%	Improved

MY: measurement year; MMC: Medicaid Managed Care

Dental and Oral Health Services

Table 20 is the full set of aggregated data for MY 2022 dental and oral health services measures validated for OMAP.

Table 20: PH-MCO Dental and Oral Health Services Measures

PH-MCO Dental and Oral Health Services Performance Measure	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Oral Evaluation - Dental Services (Total)	46.3%	46.9%	50.4%	40.2%	54.7%	37.5%	47.6%	46.2%	47.1%	Declined
Sealant Receipt on Permanent First Year Molars - At Least One Sealant	9.7%	50.3%	57.3%	54.7%	7.0%	52.1%	18.3%	35.6%	30.1%	Declined
Sealant Receipt on Permanent First Year Molars - All Four Molars Sealed	5.4%	33.4%	39.5%	39.5%	3.7%	36.6%	9.8%	24.0%	19.9%	Declined
Topical Fluoride for Children - Dental Services (Total)	17.2%	20.3%	17.2%	12.4%	21.2%	18.0%	14.4%	17.2%	17.3%	Improved
Topical Fluoride for Children - Oral Health Services (Total)	1.0%	0.2%	0.1%	1.0%	0.8%	0.7%	1.2%	0.7%	0.8%	Improved
Topical Fluoride for Children - Dental or Oral Health Services (Total)	18.9%	20.7%	20.0%	14.1%	22.8%	19.7%	16.2%	18.9%	19.0%	Improved

MY: measurement year; MMC: Medicaid Managed Care

Diabetes

Table 21 is the full set of aggregated data for MY 2022 diabetes measures validated for OMAP.

Table 21: PH-MCO Diabetes Performance Measures

PH-MCO Diabetes Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Blood Pressure Control for Patients With Diabetes[1]	73.0%	79.8%	59.6%	72.0%	64.7%	66.7%	76.2%	70.3%	71.2%	-
Eye Exam for Patients With Diabetes[1]	58.9%	67.6%	50.1%	54.7%	49.2%	51.3%	64.2%	56.6%	57.9%	-
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)[1]	56.9%	60.6%	54.0%	56.7%	52.3%	55.7%	63.5%	57.1%	58.1%	-
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control[1]	32.9%	29.2%	35.0%	33.1%	36.3%	34.8%	29.2%	32.9%	32.3%	-
Kidney Health Evaluation for Patients With Diabetes (Total)	43.5%	56.0%	45.0%	42.2%	44.2%	43.0%	46.3%	45.7%	45.9%	Improved
Statin Therapy for Patients With Diabetes - Received Statin Therapy	68.0%	66.3%	72.3%	69.6%	70.9%	68.0%	71.9%	69.6%	70.3%	Improved
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	74.8%	74.1%	68.7%	73.6%	75.8%	65.7%	79.4%	73.1%	75.0%	Improved

[1]The measures specification underwent changes in My 2022. A year-to-year comparison is not applicable during this transition period.
MY: measurement year; MMC: Medicaid Managed Care

Electronic Clinical Data Systems

Table 22 is the full set of aggregated data for MY 2022 ECDS measures validated for OMAP.

Table 22: PH-MCO ECDS Performance Measures

PH-MCO ECDS Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Adult Immunization Status - Influenza (19-65)	17.8%	17.8%	12.9%	15.9%	17.8%	15.5%	17.9%	16.5%	16.8%	Declined
Adult Immunization Status - Td/TDaP (19-65)	49.0%	55.2%	39.7%	48.9%	39.2%	48.6%	47.0%	46.8%	45.9%	Improved
Adult Immunization Status - Zoster (50-65)	13.2%	16.2%	5.2%	10.5%	11.0%	10.9%	12.2%	11.3%	11.4%	Improved
Breast Cancer Screening	58.0%	57.3%	54.4%	50.5%	53.3%	48.3%	56.3%	54.0%	55.0%	Improved
Childhood Immunization Status - Combo 3[1]	61.8%	68.8%	60.8%	60.4%	66.3%	63.8%	66.3%	64.0%	64.3%	-
Childhood Immunization Status - Combo 7[1]	52.2%	58.2%	51.5%	50.9%	58.0%	54.9%	57.8%	54.8%	55.2%	-
Childhood Immunization Status - Combo 10[1]	29.0%	30.5%	31.7%	26.3%	39.5%	36.0%	31.6%	32.1%	32.5%	-
Colorectal Cancer Screening (Total)[1]	39.5%	41.5%	32.8%	38.4%	33.3%	26.4%	43.9%	36.6%	38.4%	-
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)	2.8%	11.9%	3.7%	0.1%	3.4%	0.5%	2.4%	3.5%	3.5%	Improved
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)	63.4%	70.9%	46.0%	N/A	63.2%	N/A	77.2%	60.2%	62.4%	Declined
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	45.9%	42.6%	55.3%	44.7%	33.3%	42.5%	53.2%	45.3%	45.4%	Improved
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	53.4%	48.0%	64.0%	53.6%	43.3%	46.6%	60.4%	52.8%	53.2%	Improved
Immunizations for Adolescents - Combination 1[1]	84.6%	84.4%	79.3%	84.3%	85.9%	82.6%	85.3%	83.8%	84.2%	-
Immunizations for Adolescents - Combination 2[1]	36.7%	32.4%	41.4%	33.8%	44.6%	37.1%	35.4%	37.4%	38.0%	-
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) [1]	79.2%	83.4%	53.0%	80.0%	72.9%	71.4%	79.2%	74.2%	77.9%	-
Metabolic Monitoring for Children and Adole[1]scents on Antipsychotics - Cholesterol Testing (Total) [1]	69.1%	75.2%	60.3%	72.9%	64.1%	61.7%	68.3%	67.4%	69.2%	-
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) [1]	67.5%	74.1%	47.3%	70.3%	60.7%	60.9%	67.1%	64.0%	66.9%	-
Prenatal Depression Screening and Follow-Up - Depression Screening	26.5%	50.8%	39.7%	3.3%	44.4%	19.8%	29.9%	30.6%	31.6%	Improved
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen	49.2%	63.3%	43.3%	N/A	45.6%	50.0%	56.9%	50.8%	50.8%	Improved
Postpartum Depression Screening and Follow-Up - Depression Screening	27.6%	39.4%	44.9%	4.0%	40.0%	3.1%	38.6%	28.2%	30.5%	Improved
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen	54.2%	60.5%	46.7%	N/A	48.1%	N/A	67.8%	61.8%	59.8%	Improved
Prenatal Immunization Status - Combination	28.3%	26.9%	29.4%	24.2%	28.3%	26.0%	24.7%	26.8%	26.8%	Declined

[1]The measure was first reported in MY 2022. A year-to-year comparison is not applicable.

MY: measurement year; MMC: Medicaid Managed Care

Maternal and Perinatal Health

Table 23 is the full set of aggregated data for MY 2022 maternal and perinatal health measures validated for OMAP.

Table 23: PH-MCO Maternal and Perinatal Health Measures

PH-MCO Maternal and Perinatal Health Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Contraceptive Care - All Women - Most or Moderately Effective Contraception (Ages 15 to 44 years)	27.3%	28.3%	24.5%	26.3%	25.1%	22.3%	27.9%	26.0%	26.4%	Declined
Contraceptive Care - All Women - Long-Acting Reversible Method of Contraception (LARC) (Ages 15 to 44 years)	4.2%	3.5%	3.4%	3.6%	3.4%	2.8%	3.8%	3.5%	3.6%	Declined
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 3 Days of Delivery (Ages 15 to 44 years)	19.0%	16.2%	24.6%	16.3%	22.2%	16.6%	14.9%	18.5%	18.7%	Improved
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 90 Days of Delivery (Ages 15 to 44 years)	54.0%	48.1%	52.3%	48.6%	49.5%	46.8%	48.5%	49.7%	49.9%	Improved
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 3 Days of Delivery (Ages 15 to 44 years)	5.9%	3.8%	10.0%	5.1%	8.4%	4.9%	3.8%	6.0%	6.1%	Improved
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 90 Days of Delivery (Ages 15 to 44 years)	16.2%	12.3%	18.4%	14.1%	16.0%	13.3%	14.0%	14.9%	15.1%	Improved
Perinatal Depression Screening: Screened for depression during a postpartum care visit	92.3%	89.7%	73.8%	84.3%	81.3%	92.0%	89.8%	86.2%	86.2%	Improved
Perinatal Depression Screening: Screened for depression during a postpartum care visit using a validated depression screening tool	83.0%	70.5%	59.4%	71.1%	69.4%	79.2%	78.4%	73.0%	73.2%	Improved
Perinatal Depression Screening: Screened for depression during a prenatal care visit	92.1%	82.0%	80.8%	73.8%	92.0%	94.8%	87.5%	86.1%	86.1%	Improved
Perinatal Depression Screening: Screened for depression during a prenatal care visit using a validated depression screening tool	69.5%	58.4%	38.9%	52.0%	59.0%	58.5%	58.3%	56.4%	56.5%	Improved
Perinatal Depression Screening: Screened for depression during the time frame of the first two prenatal care visits (CHIPRA Indicator)	82.3%	80.8%	79.3%	68.0%	83.0%	88.2%	56.0%	76.8%	77.0%	Improved
Perinatal Depression Screening: Screened positive for depression during a postpartum care visit	20.4%	25.1%	11.3%	18.3%	14.4%	12.0%	31.3%	19.0%	19.2%	Improved
Perinatal Depression Screening: Screened positive for depression during a postpartum care visit and had evidence of further evaluation or treatment or referral for further treatment	85.9%	94.6%	N/A	88.7%	73.8%	91.7%	96.7%	88.6%	89.9%	Improved
Perinatal Depression Screening: Screened positive for depression during a prenatal care visit	22.3%	31.8%	13.9%	20.4%	18.7%	20.7%	24.2%	21.7%	21.7%	Improved
Perinatal Depression Screening: Screened positive for depression during a prenatal care visit and had evidence of further evaluation or treatment or referral for further treatment	77.3%	87.7%	80.0%	81.5%	74.0%	82.5%	87.1%	81.5%	82.0%	Improved

PH-MCO Maternal and Perinatal Health Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PH Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke Exposure (ETS)	67.4%	95.1%	N/A	N/A	N/A	76.5%	81.3%	69.6%	76.2%	Improved
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking	61.7%	83.8%	53.3%	59.5%	45.9%	79.7%	67.0%	64.4%	67.1%	Declined
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS)	61.1%	49.5%	60.1%	34.8%	64.9%	61.7%	57.9%	55.7%	55.6%	Improved
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking	90.0%	93.8%	78.1%	62.4%	92.5%	89.2%	92.9%	85.6%	85.4%	Improved
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	88.6%	93.8%	77.6%	62.2%	91.7%	88.9%	92.9%	85.1%	84.9%	Improved
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation	37.5%	10.8%	N/A	16.2%	46.6%	20.3%	20.9%	26.7%	24.6%	Declined

MY: measurement year; MMC: Medicaid Managed Care; LARC: long-acting reversible method of contraception; CHIPRA; Children's Health Insurance Program Reauthorization Act; N/A: not applicable or the denominator was less than 30.

Overuse/Appropriateness

Table 24 is the full set of aggregated data for MY 2022 overuse/appropriateness measures validated for OMAP.

Table 24: PH-MCO Overuse/Appropriateness Performance Measures

PH-MCO Overuse/Appropriateness Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Appropriate Treatment for Upper Respiratory Infection (Total)	92.4%	89.9%	94.4%	93.7%	94.4%	93.3%	91.4%	92.8%	92.5%	Improved
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	65.6%	61.8%	76.1%	68.2%	74.7%	69.0%	62.1%	68.2%	66.7%	Improved
Concurrent Use of Opioids and Benzodiazepines (Total)	19.3%	19.1%	12.6%	17.4%	18.4%	11.4%	16.1%	16.3%	16.6%	Improved
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.2%	0.9%	0.0%	0.2%	0.1%	0.1%	0.3%	0.2%	0.2%	Declined
Risk of Continued Opioid Use - >=15 Days (Total)	1.6%	2.4%	4.9%	3.5%	2.9%	2.8%	6.3%	3.5%	3.9%	Improved
Risk of Continued Opioid Use - >=31 Days (Total)	1.3%	1.7%	3.0%	2.2%	2.5%	2.2%	3.9%	2.4%	2.6%	Improved
Use of Imaging Studies for Low Back Pain (Total)	72.9%	73.5%	80.0%	72.7%	79.5%	75.3%	76.1%	75.7%	75.8%	Declined
Use of Opioids at High Dosage	7.8%	6.8%	5.1%	6.8%	17.6%	8.9%	6.6%	8.5%	7.9%	Declined
Use of Opioids From Multiple Providers - Multiple Pharmacies	0.9%	0.3%	0.9%	0.9%	1.2%	2.6%	1.7%	1.2%	1.4%	Improved
Use of Opioids From Multiple Providers - Multiple Prescribers	10.5%	13.4%	14.7%	13.1%	11.0%	14.3%	18.1%	13.6%	15.7%	Improved
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	0.2%	0.1%	0.5%	0.5%	0.5%	1.6%	1.0%	0.6%	0.8%	Improved

MY: measurement year; MMC: Medicaid Managed Care

Prevention and Screening

Table 25 is the full set of aggregated data for MY 2022 prevention and screening measures validated for OMAP.

Table 25: PH-MCO Prevention and Screening Performance Measures

PH-MCO Prevention and Screening Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Breast Cancer Screening	58.1%	57.4%	54.5%	50.7%	53.4%	48.5%	56.4%	54.1%	55.1%	Improved
Cervical Cancer Screening	63.3%	62.2%	57.3%	60.3%	55.6%	51.1%	57.1%	58.1%	58.5%	Declined
Childhood Immunization Status - Combo 3	68.6%	69.8%	67.9%	70.6%	68.9%	69.3%	63.8%	68.4%	68.0%	Declined
Childhood Immunization Status - Combo 7	58.4%	62.3%	58.6%	59.6%	62.0%	61.6%	54.0%	59.5%	59.1%	Improved
Childhood Immunization Status - Combo 10	32.4%	34.1%	41.9%	34.3%	45.3%	40.9%	27.7%	36.6%	36.4%	Declined
Chlamydia Screening in Women (Total)	51.4%	50.3%	66.5%	54.5%	66.7%	66.2%	51.3%	58.1%	57.3%	Improved
Colorectal Cancer Screening (Total) [1]	40.0%	42.1%	33.6%	38.9%	33.8%	27.1%	44.7%	37.2%	39.0%	-
Developmental Screening in the First Three Years of Life - Total	57.8%	32.0%	56.7%	69.1%	64.6%	64.1%	74.1%	59.8%	62.0%	Improved
Immunizations for Adolescents - Combination 1	86.9%	86.9%	86.1%	89.3%	85.9%	83.5%	88.8%	86.8%	87.0%	Improved
Immunizations for Adolescents - Combination 2	39.7%	32.4%	46.7%	39.7%	44.6%	37.5%	36.5%	39.6%	40.1%	Improved
Lead Screening in Children	80.5%	86.6%	74.2%	85.4%	81.8%	79.5%	83.9%	81.7%	81.9%	Improved
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	75.4%	82.2%	85.4%	86.4%	85.7%	87.6%	80.0%	83.2%	82.5%	Declined
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	71.5%	72.2%	79.5%	77.1%	73.2%	83.5%	71.9%	75.6%	74.1%	Declined
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	68.2%	70.5%	71.0%	73.0%	70.7%	79.6%	70.6%	71.9%	70.9%	Declined

[1]The measure was first reported in MY 2022. A year-to-year comparison is not applicable.
MY: measurement year; MMC: Medicaid Managed Care; BMI: body mass index

Race and Ethnicity Stratifications

Table 26 is the full set of aggregated data for MY 2022 race and ethnicity stratifications validated for OMAP.

Table 26: PH-MCO Race and Ethnicity Stratifications

PH-MCO Measures	Race and Ethnicity Stratification	ACP	GEI	HPP	HWC	KF	UHC	UPMC	MY 2022 MMC
Child and Adolescent Well-Care Visits	Ethnicity: Asked but No Answer	N/A	61.2%	N/A	N/A	N/A	N/A	N/A	61.2%
Child and Adolescent Well-Care Visits	Ethnicity: Hispanic or Latino	60.6%	60.3%	61.9%	58.8%	63.2%	64.7%	62.0%	61.2%
Child and Adolescent Well-Care Visits	Ethnicity: Not Hispanic or Latino	56.5%	56.5%	54.4%	57.3%	58.7%	54.9%	62.4%	58.3%
Child and Adolescent Well-Care Visits	Ethnicity: Unknown	N/A	53.0%	61.0%	57.1%	N/A	48.6%	60.5%	55.8%
Child and Adolescent Well-Care Visits	Race: American Indian and Alaska Native	56.3%	53.2%	N/A	61.4%	59.1%	58.2%	56.8%	57.7%
Child and Adolescent Well-Care Visits	Race: Asian	61.8%	61.1%	57.8%	61.6%	65.5%	58.8%	N/A	62.8%
Child and Adolescent Well-Care Visits	Race: Asked but No Answer	N/A	56.8%	N/A	N/A	N/A	N/A	64.7%	64.4%
Child and Adolescent Well-Care Visits	Race: Black or African American	56.8%	56.7%	54.2%	54.8%	57.2%	54.3%	57.8%	56.2%
Child and Adolescent Well-Care Visits	Race: Native Hawaiian and Other Pacific Islander	52.4%	58.1%	N/A	N/A	40.7%	N/A	N/A	57.2%
Child and Adolescent Well-Care Visits	Race: Some Other Race	N/A	64.9%	61.8%	N/A	N/A	N/A	N/A	61.8%
Child and Adolescent Well-Care Visits	Race: Two or More Races	60.9%	N/A	N/A	N/A	62.9%	N/A	64.1%	62.1%
Child and Adolescent Well-Care Visits	Race: Unknown	N/A	56.9%	49.6%	59.9%	N/A	59.5%	70.8%	59.4%
Child and Adolescent Well-Care Visits	Race: White	57.3%	57.0%	54.0%	58.0%	59.9%	55.1%	63.2%	59.2%
Colorectal Cancer Screening	Ethnicity: Asked but No Answer	N/A	51.1%	N/A	N/A	N/A	N/A	N/A	51.1%
Colorectal Cancer Screening	Ethnicity: Hispanic or Latino	45.8%	47.3%	39.5%	44.7%	35.2%	33.3%	42.0%	42.8%
Colorectal Cancer Screening	Ethnicity: Not Hispanic or Latino	37.2%	41.7%	30.7%	37.4%	33.2%	26.1%	44.0%	38.5%
Colorectal Cancer Screening	Ethnicity: Unknown	N/A	27.5%	N/A	37.4%	N/A	N/A	N/A	35.8%
Colorectal Cancer Screening	Race: American Indian and Alaska Native	35.8%	40.9%	N/A	38.5%	34.8%	N/A	42.0%	38.4%
Colorectal Cancer Screening	Race: Asian	44.0%	44.5%	38.0%	44.3%	41.5%	34.7%	N/A	41.0%
Colorectal Cancer Screening	Race: Asked but No Answer	N/A	48.5%	N/A	N/A	N/A	N/A	42.0%	42.2%
Colorectal Cancer Screening	Race: Black or African American	37.4%	39.3%	30.9%	36.1%	31.9%	24.9%	42.2%	34.2%
Colorectal Cancer Screening	Race: Native Hawaiian and Other Pacific Islander	N/A	49.0%	N/A	N/A	N/A	N/A	N/A	49.0%
Colorectal Cancer Screening	Race: Some Other Race	N/A	42.5%	37.9%	N/A	N/A	N/A	N/A	38.9%
Colorectal Cancer Screening	Race: Two or More Races	45.2%	N/A	N/A	N/A	31.6%	N/A	43.4%	40.4%
Colorectal Cancer Screening	Race: Unknown	N/A	31.7%	26.4%	42.5%	N/A	29.0%	N/A	37.9%
Colorectal Cancer Screening	Race: White	38.3%	41.8%	29.6%	38.0%	32.4%	25.7%	44.4%	40.4%
Controlling High Blood Pressure	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Controlling High Blood Pressure	Ethnicity: Hispanic or Latino	71.5%	72.7%	60.7%	69.6%	75.7%	N/A	N/A	68.0%
Controlling High Blood Pressure	Ethnicity: Not Hispanic or Latino	75.7%	71.2%	61.9%	73.9%	65.0%	63.5%	74.3%	70.6%
Controlling High Blood Pressure	Ethnicity: Unknown	N/A	N/A	N/A	74.5%	N/A	N/A	N/A	70.4%

PH-MCO Measures	Race and Ethnicity Stratification	ACP	GEI	HPP	HWC	KF	UHC	UPMC	MY 2022 MMC
Controlling High Blood Pressure	Race: American Indian and Alaska Native	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.8%
Controlling High Blood Pressure	Race: Asian	N/A	N/A	N/A	N/A	79.5%	N/A	N/A	74.3%
Controlling High Blood Pressure	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	58.9%
Controlling High Blood Pressure	Race: Black or African American	63.0%	67.7%	61.7%	62.5%	57.0%	58.8%	50.0%	58.3%
Controlling High Blood Pressure	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	60.0%
Controlling High Blood Pressure	Race: Some Other Race	N/A	N/A	58.0%	N/A	N/A	N/A	N/A	58.0%
Controlling High Blood Pressure	Race: Two or More Races	73.4%	N/A	N/A	N/A	78.4%	N/A	N/A	74.3%
Controlling High Blood Pressure	Race: Unknown	N/A	N/A	N/A	64.2%	N/A	67.1%	N/A	63.1%
Controlling High Blood Pressure	Race: White	77.4%	71.3%	64.1%	79.7%	71.9%	70.0%	79.4%	76.4%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Ethnicity: Hispanic or Latino	52.4%	52.8%	55.1%	50.0%	56.8%	N/A	N/A	52.7%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Ethnicity: Not Hispanic or Latino	59.5%	62.7%	53.6%	58.6%	51.8%	55.4%	64.3%	59.1%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Ethnicity: Unknown	N/A	N/A	N/A	56.5%	N/A	N/A	N/A	55.3%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: American Indian and Alaska Native	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48.2%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: Asian	N/A	N/A	N/A	N/A	64.4%	66.7%	N/A	65.9%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	62.9%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: Black or African American	47.9%	58.3%	50.6%	47.5%	48.9%	53.9%	67.5%	53.1%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75.0%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: Some Other Race	N/A	N/A	56.6%	N/A	N/A	N/A	N/A	56.6%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: Two or More Races	60.0%	N/A	N/A	N/A	60.0%	N/A	N/A	65.5%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: Unknown	N/A	N/A	N/A	55.8%	N/A	49.4%	N/A	54.9%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8%)	Race: White	56.6%	60.5%	56.4%	58.9%	51.2%	61.0%	60.6%	58.7%

PH-MCO Measures	Race and Ethnicity Stratification	ACP	GEI	HPP	HWC	KF	UHC	UPMC	MY 2022 MMC
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.0%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Ethnicity: Hispanic or Latino	37.4%	39.6%	33.9%	33.8%	29.6%	N/A	N/A	35.7%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Ethnicity: Not Hispanic or Latino	30.3%	26.8%	35.5%	33.0%	37.1%	35.3%	28.6%	31.6%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Ethnicity: Unknown	N/A	N/A	N/A	32.6%	N/A	N/A	N/A	34.6%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: American Indian and Alaska Native	N/A	N/A	N/A	N/A	N/A	N/A	N/A	16.2%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: Asian	N/A	N/A	N/A	N/A	15.6%	26.7%	N/A	19.8%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	29.4%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: Black or African American	39.6%	36.1%	37.8%	42.5%	41.0%	37.7%	28.6%	37.7%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	25.0%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: Some Other Race	N/A	N/A	34.1%	N/A	N/A	N/A	N/A	34.1%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: Two or More Races	32.5%	N/A	N/A	N/A	24.4%	N/A	N/A	26.2%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: Unknown	N/A	N/A	N/A	29.9%	N/A	38.8%	N/A	31.5%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9%)	Race: White	32.6%	28.7%	32.1%	31.5%	40.2%	28.6%	30.7%	31.7%
Prenatal and Postpartum Care: Postpartum Care	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care: Postpartum Care	Ethnicity: Hispanic or Latino	83.0%	86.4%	83.9%	79.5%	83.0%	N/A	N/A	83.8%
Prenatal and Postpartum Care: Postpartum Care	Ethnicity: Not Hispanic or Latino	87.2%	78.5%	77.6%	77.4%	81.3%	79.8%	83.3%	81.1%
Prenatal and Postpartum Care: Postpartum Care	Ethnicity: Unknown	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75.8%
Prenatal and Postpartum Care: Postpartum Care	Race: American Indian and Alaska Native	N/A	N/A	N/A	N/A	N/A	N/A	N/A	52.7%
Prenatal and Postpartum Care: Postpartum Care	Race: Asian	N/A	N/A	N/A	N/A	91.2%	N/A	N/A	89.5%
Prenatal and Postpartum Care: Postpartum Care	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	91.6%
Prenatal and Postpartum Care: Postpartum Care	Race: Black or African American	84.3%	75.5%	73.5%	68.3%	82.2%	73.8%	75.0%	77.2%
Prenatal and Postpartum Care: Postpartum Care	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75.0%

PH-MCO Measures	Race and Ethnicity Stratification	ACP	GEI	HPP	HWC	KF	UHC	UPMC	MY 2022 MMC
Prenatal and Postpartum Care: Postpartum Care	Race: Some Other Race	N/A	N/A	86.5%	N/A	N/A	N/A	N/A	86.5%
Prenatal and Postpartum Care: Postpartum Care	Race: Two or More Races	84.8%	N/A	N/A	N/A	80.0%	N/A	N/A	84.1%
Prenatal and Postpartum Care: Postpartum Care	Race: Unknown	N/A	N/A	N/A	87.8%	N/A	84.7%	N/A	86.1%
Prenatal and Postpartum Care: Postpartum Care	Race: White	85.7%	80.3%	78.0%	78.9%	77.5%	83.3%	85.5%	82.3%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Ethnicity: Hispanic or Latino	89.8%	89.4%	90.8%	91.6%	83.0%	N/A	N/A	89.8%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Ethnicity: Not Hispanic or Latino	91.1%	89.0%	86.1%	87.3%	87.6%	88.6%	89.7%	88.5%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Ethnicity: Unknown	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80.0%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: American Indian and Alaska Native	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.8%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: Asian	N/A	N/A	N/A	N/A	94.1%	N/A	N/A	91.7%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	92.8%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: Black or African American	90.2%	89.8%	85.5%	86.1%	85.3%	85.1%	82.5%	85.6%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75.0%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: Some Other Race	N/A	N/A	90.2%	N/A	N/A	N/A	N/A	90.2%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: Two or More Races	90.2%	N/A	N/A	N/A	80.0%	N/A	N/A	87.7%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: Unknown	N/A	N/A	N/A	94.6%	N/A	87.5%	N/A	91.5%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Race: White	91.1%	88.7%	86.8%	87.2%	91.0%	92.2%	91.8%	90.2%

N/A: not applicable, as denominator is less than 30; MMC: Medicaid Managed Care

Respiratory Conditions

Table 27 is the full set of aggregated data for MY 2022 respiratory conditions measures validated for OMAP.

Table 27: PH-MCO Respiratory Conditions Performance Measures

PH-MCO Respiratory Conditions Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 PH MMC Weighted Average Compared to MY 2021
Appropriate Testing for Pharyngitis (Total)	61.0%	62.9%	58.2%	69.9%	60.5%	69.6%	70.3%	64.6%	65.6%	Improved
Asthma Medication Ratio (Total)	67.3%	62.9%	67.7%	68.8%	64.2%	59.6%	68.8%	65.6%	66.3%	Improved
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	90.6%	86.7%	88.9%	87.0%	89.9%	83.1%	88.7%	87.9%	88.3%	Improved
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	82.4%	78.3%	71.9%	79.5%	75.8%	71.3%	80.5%	77.1%	78.3%	Improved
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	25.5%	27.6%	18.7%	25.1%	22.7%	22.0%	22.9%	23.5%	23.4%	Declined

MY: measurement year; MMC: Medicaid Managed Care; BMI: body mass index; COPD: chronic obstructive pulmonary disease

Utilization

Table 28 is the full set of aggregated data for MY 2022 utilization measures validated for OMAP.

Table 28: PH-MCO Utilization Performance Measures

PH-MCO Utilization Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 Weighted Average Compared to MY 2021
Ambulatory Care - Emergency Dept Visits/1000 MY (Total) [1]	724.0	568.3	556.3	661.1	556.1	580.5	652.7	614.1	617.7	Improved
Ambulatory Care - Outpatient Visits/1000 MY (Total) [1]	4,465.8	4,200.3	2,948.0	3,954.3	3,125.1	3,300.2	5,414.4	3,915.4	4,036.9	Improved
Antibiotic Utilization for Respiratory Conditions (Total)[2]	17.6%	22.8%	10.7%	17.1%	12.1%	16.3%	21.9%	16.9%	17.6%	-
Asthma in Younger Adults Admission Rate (Total Age 2 to 39 years) per 100,000 member months	6.3	4.1	13.5	8.9	19.8	8.2	7.8	9.8	10.4	Improved
Child and Adolescent Well-Care Visits (Total)	58.2%	57.0%	56.9%	57.6%	59.4%	56.0%	62.4%	58.2%	58.9%	Improved
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 years and older) per 100,000 member months	23.7	23.0	24.0	36.7	44.6	36.9	45.8	33.5	35.9	Improved
Diabetes Short-Term Complications Admission Rate (Age 18 years and older) per 100,000 member months	16.1	15.0	10.7	20.7	18.7	15.7	15.9	16.1	16.2	Declined
Frequency of Selected Procedures - Back Surgery (F 20-44) [3]	1.7	1.7	0.7	1.5	0.9	1.3	1.9	1.4	-	-
Frequency of Selected Procedures - Back Surgery (F 45-64) [3]	5.4	5.8	2.6	5.3	3.3	4.2	7.3	4.8	-	-
Frequency of Selected Procedures - Back Surgery (M 20-44) [3]	1.4	2.0	1.1	1.9	1.1	1.2	2.0	1.5	-	-
Frequency of Selected Procedures - Back Surgery (M 45-64) [3]	6.6	6.7	2.8	5.5	3.8	4.7	7.1	5.3	-	-
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 0-19) [3]	0.2	0.0	0.2	0.0	0.2	0.2	0.1	0.1	-	-
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 20-44) [3]	7.2	3.7	4.3	4.0	3.2	5.9	3.8	4.6	-	-
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 45-64) [3]	4.8	3.0	3.3	3.2	1.9	3.2	3.2	3.2	-	-
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 0-19) [3]	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	-	-
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 20-44) [3]	1.0	0.6	0.6	0.5	0.5	0.8	0.6	0.6	-	-
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 45-64) [3]	1.3	0.8	0.6	0.5	0.6	0.7	0.6	0.7	-	-
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 15-44) [3]	7.2	6.7	3.6	5.9	3.2	4.4	7.0	5.4	-	-
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 45-64) [3]	5.8	5.9	2.7	6.0	3.5	4.9	5.8	5.0	-	-
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (M 30-64) [3]	2.4	2.8	1.2	2.1	1.2	1.7	3.3	2.1	-	-
Frequency of Selected Procedures - Cholecystectomy Open (F 15-44) [3]	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	-	-
Frequency of Selected Procedures - Cholecystectomy Open (F 45-64) [3]	0.3	0.2	0.1	0.2	0.1	0.3	0.4	0.2	-	-
Frequency of Selected Procedures - Cholecystectomy Open (M 30-64) [3]	0.3	0.2	0.2	0.3	0.3	0.3	0.2	0.3	-	-
Frequency of Selected Procedures - Hysterectomy Abdominal (15-44) [3]	0.8	0.7	0.5	0.6	0.7	0.3	0.6	0.6	-	-
Frequency of Selected Procedures - Hysterectomy Abdominal (45-64) [3]	1.7	1.5	1.2	1.6	2.0	0.9	1.3	1.4	-	-
Frequency of Selected Procedures - Hysterectomy Vaginal (15-44) [3]	1.0	0.5	0.5	0.8	0.4	0.5	1.0	0.7	-	-

PH-MCO Utilization Performance Measures	ACP	GEI	HPP	HWC	KF	UHC	UPMC	PA Mean	PH MMC Weighted Average	MY 2022 Weighted Average Compared to MY 2021
Frequency of Selected Procedures - Hysterectomy Vaginal (45-64) [3]	1.2	0.8	1.3	1.1	1.1	0.6	1.0	1.0	-	-
Frequency of Selected Procedures - Lumpectomy (F 15-44) [3]	1.3	1.3	1.0	0.9	1.1	0.9	1.1	1.1	-	-
Frequency of Selected Procedures - Lumpectomy (F 45-64) [3]	4.6	2.9	2.9	2.9	3.8	3.4	3.2	3.4	-	-
Frequency of Selected Procedures - Mastectomy (F 15-44) [3]	0.8	0.6	0.9	0.5	1.5	0.8	0.8	0.8	-	-
Frequency of Selected Procedures - Mastectomy (F 45-64) [3]	1.8	1.5	1.3	1.1	1.9	2.0	1.4	1.6	-	-
Frequency of Selected Procedures - Tonsillectomy (M/F 0-9) [3]	5.9	5.2	3.7	4.4	4.0	3.8	5.3	4.6	-	-
Frequency of Selected Procedures - Tonsillectomy (M/F 10-19) [3]	2.4	2.2	1.4	2.2	1.4	1.5	2.6	2.0	-	-
Heart Failure Admission Rate (Age 18 years and older) per 100,000 member months	16.5	12.6	15.1	24.6	24.9	20.0	34.9	21.2	23.0	Improved
Inpatient Utilization - General Hospital/Acute Care – Medicine Discharges/1000 MY (Total) [3]	29.8	31.7	27.8	33.6	42.4	31.5	39.4	33.7	-	-
Inpatient Utilization - General Hospital/Acute Care – Surgery Discharges/1000 MY (Total) [3]	14.5	13.8	15.1	17.2	15.1	15.5	24.0	16.5	-	-
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges/1000 MY (Total) [3]	26.1	22.1	22.9	24.5	25.1	20.8	22.5	23.4	-	-
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges/1000 MY (Total) [3]	63.7	62.3	60.5	69.1	76.1	63	80.2	67.8	-	-
Plan All-Cause Readmissions – Observed to Expected Readmission Ratio – Total stays (18-64) [3]	1.0	0.8	1.1	0.9	1.1	1.1	0.8	1.0	-	-
Well-Child Visits in the First 30 Months of Life (First 15 Months)	70.5%	66.0%	59.3%	70.4%	64.2%	60.1%	77.8%	66.9%	68.1%	Improved
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	75.4%	75.3%	66.3%	74.6%	71.0%	70.7%	80.6%	73.4%	74.0%	Improved

[1]HEDIS measure Ambulatory Care calculations changed from member months in MY 2021 to member years in MY 2022. Per NCQA guidance, MY 2021 rates were multiplied by 12 to trend data to MY 2022.
[2]The measure was first reported in MY 2022. A year-to-year comparison is not applicable.
[3]Utilization measures are designed to capture the frequency of certain services provided by the organization. NCQA does not view higher or lower service counts as indicating better or worse performance. A year-to-year comparison is not applicable.
MY: measurement year; MMC: Medicaid Managed Care; M: male; F: female; M/F: male and female

CHIP-MCO Performance Measures

CHIP-MCO PAPM Validation

Each MCO submitted data and underwent validation for the one required PA-Specific measure in MY 2022.

CHIP-MCO Core Set Measures Validation

Each MCO submitted data and underwent validation for the six required Child Core Set measures in MY 2022.

CHIP-MCO HEDIS Health Plan Measures Validation

Each MCO underwent a full HEDIS compliance audit in 2023. Development of HEDIS Health Plan measures and the clinical rationale for their inclusion in the HEDIS Health Plan measurement set can be found in the HEDIS MY 2022, Volume 2 narrative. Each year, DHS updates its requirements for the MCOs to be consistent with NCQA's requirement for the reporting year.

CHIP-MCOs were required to report race and ethnicity stratifications for Prenatal and Postpartum Care and Child and Adolescent Well-Care Visits for MY 2022. Race and ethnicity stratifications are reported in **Table 36**.

Consumer Assessment of Healthcare Providers and Systems Survey

The CAHPS program includes many products designed to capture consumer and patient perspectives on health care quality. Survey sample frame validation is conducted by NCQA-certified auditors for the Child Medicaid CAHPS. DHS required the MCOs to produce the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H − Child Survey, excluding the Chronic Conditions component.

For the Child Medicaid CAHPS, all CHIP-MCOs' survey sample frames were deemed valid by the NCQA-certified auditor. CHIP-MCO survey results are presented in **Table 76** in **Section VII: Validation of Quality-of-Care Surveys.**

CHIP-MCO Conclusions and Comparative Findings

The MCOs successfully completed the HEDIS audit. The MCOs received an audit designation of report for all applicable measures. Additionally, the MCOs successfully implemented all of the required measures for MY 2022 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCOs. All rates submitted by the MCO were reportable.

Tables 29–**38** represent the aggregated performance measure data for all eight CHIP-MCOs in 2023, as well as the PA mean and the CHIP weighted average, which takes into account the proportional relevance of each MCO. The aggregated data includes combined stratifications and total age groups, as applicable. If the denominator was less than 30 for a particular rate, "N/A" (Not Applicable) appears in the corresponding cells. Additionally, each table reports improvement or decline in the weighted average from the previous year.

The individual CHIP-MCO MY 2022 EQR reports present a subset of these measures that include the complete measure stratification and age group breakouts. Additionally, the individual CHIP-MCO reports include:

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

Access to/Availability of Care

Table 29 is the full set of aggregated data for MY 2022 access to/availability of care measures validated for CHIP.

Table 29: CHIP-MCO Access to/Availability of Care Performance Measures

CHIP-MCO Access to/Availability of Care Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 CHIP Weighted Average Compared to MY 2021
Annual Dental Visit (Total)	62.8%	61.1%	65.0%	61.9%	60.7%	66.7%	63.4%	65.8%	63.4%	63.8%	Declined
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	65.9%	65.9%	65.9%	Declined

MY: measurement year; N/A: not applicable, the denominator was less than 30

Behavioral Health

Table 30 is the full set of aggregated data for MY 2022 behavioral health measures validated for CHIP.

Table 30: CHIP-MCO Behavioral Health Performance Measures

CHIP-MCO Behavioral Health Services Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 CHIP Weighted Average Compared to MY 2021
Diagnosed Mental Health Disorders (Total)[1]	12.2%	17.6%	16.7%	19.1%	9.98%	13.8%	14.8%	20.6%	15.6%	16.4%	-
Diagnosed Substance Use Disorders - Alcohol (Total)[2]	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	-
Diagnosed Substance Use Disorders - Any (Total)[2]	0.6%	0.6%	0.5%	0.7%	0.4%	0.5%	0.6%	0.7%	0.6%	0.6%	-
Diagnosed Substance Use Disorders - Opioid (Total)[2]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-
Diagnosed Substance Use Disorders - Other (Total)[2]	0.4%	0.5%	0.5%	0.6%	0.3%	0.5%	0.4%	0.6%	0.5%	0.5%	-
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)[3]	32.4%	46.2%	50.0%	47.7%	N/A	N/A	48.2%	55.6%	46.7%	48.6%	-
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)[3]	44.1%	74.4%	71.1%	69.2%	N/A	N/A	72.2%	77.8%	68.1%	70.5%	-
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)[4]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)[4]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)	50.0%	43.8%	44.1%	42.6%	N/A	50.0%	60.3%	60.0%	50.1%	51.5%	Declined
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)	65.2%	66.7%	72.9%	75.4%	N/A	68.8%	79.4%	78.2%	72.4%	73.3%	Improved
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	38.2%	45.1%	47.4%	43.1%	25.8%	37.8%	50.6%	56.1%	43.0%	46.9%	Improved

CHIP-MCO Behavioral Health Services Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 CHIP Weighted Average Compared to MY 2021
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	N/A	N/A	N/A	59.6%	N/A	N/A	55.3%	62.1%	59.0%	59.4%	Improved
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	N/A	N/A	62.5%	72.9%	N/A	N/A	N/A	71.2%	68.9%	69.5%	Improved
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	N/A	N/A	47.5%	41.7%	N/A	N/A	N/A	65.2%	51.4%	53.3%	Declined
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	N/A	N/A	45.0%	41.7%	N/A	N/A	N/A	60.6%	49.1%	50.7%	Improved

[1]The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.
[2]The measure provides information on the diagnosed prevalence of substance use disorders. Neither a higher nor lower rate indicates better performance.
[3]The youngest age group expanded from ages 13-17 years in MY 2021 to ages 6-17 years in MY 2022. A year-to-year comparison is not applicable during this transition.
[4]The specification underwent severe changes in MY 2022. A year-to-year comparison is not applicable during this transition period.
MY: measurement year; N/A: not applicable, the denominator was less than 30

Dental and Oral Health Services

Table 31 is the full set of aggregated data for MY 2022 dental and oral health services measures validated for CHIP.

Table 31: CHIP-MCO Dental and Oral Health Services Performance Measures

CHIP-MCO Dental and Oral Health Services Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 CHIP Weighted Average Compared to MY 2021
Oral Evaluation, Dental Services (Age <1-20 years) [1]	40.7%	4.7%	48.9%	53.4%	54.3%	42.2%	51.8%	52.4%	46.5%	42.2%	-
Sealant Receipt on Permanent First Molars (1 Molar)	19.9%	50.5%	49.4%	43.8%	51.3%	55.0%	54.9%	19.0%	43.0%	40.0%	Improved
Sealant Receipt on Permanent First Molars (All 4 Molars)	11.8%	37.8%	34.6%	33.6%	34.4%	39.1%	40.1%	11.7%	30.4%	28.2%	Improved
Topical Fluoride for Children (Dental Services) [1]	16.0%	1.1%	21.1%	21.5%	23.6%	18.6%	21.9%	21.3%	18.1%	19.0%	-
Topical Fluoride for Children (Dental/Oral Health Services) [1]	19.4%	21.3%	21.5%	21.8%	23.9%	28.3%	22.8%	22.0%	22.6%	22.6%	-
Topical Fluoride for Children (Oral Health Services) [1]	0.2%	0.1%	0.2%	0.2%	0.0%	9.0%	0.4%	0.4%	1.5%	1.3%	-

[1]The measure was first reported in MY 2022. A year-to-year comparison is not applicable.
MY: measurement year.

Electronic Clinical Data Systems

Table 32 is the full set of aggregated data for MY 2022 electronic clinical data systems measures validated for CHIP.

Table 32: CHIP-MCO ECDS Performance Measures

CHIP-MCO ECDS Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 CHIP Weighted Average Compared to MY 2021
Childhood Immunization Status – Combination 3[1]	69.9%	61.5%	72.2%	68.9%	39.1%	69.6%	78.2%	73.8%	66.6%	70.6%	-
Childhood Immunization Status - Combination 7[1]	58.9%	59.3%	63.2%	62.8%	37.5%	65.2%	74.9%	66.4%	61.0%	64.2%	-
Childhood Immunization Status - Combination 10[1]	40.2%	34.1%	42.1%	43.9%	25.0%	54.8%	53.9%	44.2%	42.3%	44.4%	-
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase[1]	38.2%	45.1%	47.4%	43.1%	25.8%	37.8%	50.6%	56.1%	43.0%	46.9%	-
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase[1]	N/A	N/A	N/A	59.6%	N/A	N/A	55.3%	62.1%	59.0%	59.4%	-

[1]The measure was first reported in MY 2022. A year-to-year comparison is not applicable.
MY: measurement year; NA: not applicable, the denominator was less than 30

Maternal and Perinatal Health

Table 33 is the full set of aggregated data for MY 2022 maternal and perinatal health measures validated for CHIP.

Table 33: CHIP-MCO Maternal and Perinatal Health Performance Measures

CHIP-MCO Maternal & Perinatal Health Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 Weighted Average Compared to MY 2021
Contraceptive Care for All Women (15–20 years): LARC	1.7%	1.5%	2.6%	1.7%	0.7%	0.7%	1.6%	2.1%	1.6%	1.6%	Improved
Contraceptive Care for All Women (15–20 years): Most or Moderately Effective	17.1%	25.8%	28.1%	28.0%	13.7%	16.1%	20.6%	27.9%	22.2%	22.9%	Improved
Contraceptive Care for Postpartum Women (15–20 years): LARC— 3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contraceptive Care for Postpartum Women (15–20 years): LARC— 60 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contraceptive Care for Postpartum Women (15–20 years): Most or moderately effective contraception— 3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contraceptive Care for Postpartum Women (15–20 years): Most or moderately effective contraception—60 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

MY: measurement year; LARC: long-acting reversible method of contraception; N/A: not applicable, the denominator was less than 30.

Overuse/Appropriateness

Table 34 is the full set of aggregated data for MY 2022 overuse/appropriateness measures validated for CHIP.

Table 34: CHIP-MCO Overuse/Appropriateness Performance Measures

CHIP-MCO Overuse/Appropriateness Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 Weighted Average Compared to MY 2021
Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2–19 years)	12.0%	4.6%	5.4%	5.9%	9.7%	13.6%	10.3%	8.4%	8.7%	9.1%	Declined
Appropriate Treatment for Upper Respiratory Infection (Total)	95.8%	93.3%	92.4%	93.0%	96.2%	95.5%	94.5%	94.5%	94.4%	94.2%	Improved

MY: measurement year.

Prevention and Screening

Table 35 is the full set of aggregated data for MY 2022 prevention and screening measures validated for CHIP.

Table 35: CHIP-MCO Prevention and Screening Performance Measures

CHIP-MCO Prevention and Screening Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 CHIP Weighted Average Compared to MY 2021
Childhood Immunization Status – Combination 3	78.5%	69.2%	75.9%	80.4%	68.8%	80.9%	84.4%	79.8%	77.2%	79.0%	Improved
Childhood Immunization Status - Combination 7	68.5%	65.9%	68.4%	73.7%	62.5%	75.7%	79.8%	71.9%	70.8%	72.1%	Declined
Childhood Immunization Status - Combination 10	47.5%	37.4%	45.9%	48.0%	40.6%	63.5%	58.0%	46.7%	48.4%	49.3%	Improved
Chlamydia Screening in Women (16-20)	41.9%	24.1%	37.2%	27.8%	37.0%	48.7%	37.2%	36.9%	36.3%	36.1%	Declined
Developmental Screening in the First Three Years of Life— Total	71.5%	55.6%	57.3%	70.7%	63.5%	70.5%	69.6%	74.2%	66.6%	69.2%	Improved
Immunizations for Adolescents - Combination 1	87.8%	89.5%	88.1%	89.5%	84.9%	90.5%	91.0%	89.3%	88.8%	89.2%	Improved
Immunizations for Adolescents - Combination 2	37.5%	29.7%	29.4%	32.6%	40.2%	47.0%	40.4%	38.2%	36.9%	37.6%	Improved
Lead Screening in Children	67.1%	61.5%	64.7%	73.7%	64.1%	55.7%	69.1%	79.3%	66.9%	70.0%	Declined
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	86.4%	82.2%	79.8%	85.2%	81.2%	86.8%	85.9%	84.7%	84.0%	84.6%	Improved
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	78.1%	75.0%	70.8%	79.3%	79.7%	83.6%	79.3%	78.7%	78.1%	78.4%	Improved
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	76.9%	73.3%	70.8%	77.6%	76.1%	81.6%	80.3%	76.8%	76.7%	77.2%	Improved

MY: measurement year; BMI: body mass index

Race and Ethnicity Stratifications

Table 36 is the full set of aggregated data for MY 2022 race and ethnicity stratifications validated for CHIP.

Table 36: CHIP-MCO Race and Ethnicity Stratifications

CHIP-MCO Measures	Race and Ethnicity Stratification	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	CHIP WA
Child and Adolescent Well-Care Visits	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Child and Adolescent Well-Care Visits	Ethnicity: Hispanic or Latino	57.5%	N/A	70.2%	80.6%	N/A	56.1%	65.2%	63.4%	62.9%
Child and Adolescent Well-Care Visits	Ethnicity: Not Hispanic or Latino	66.1%	63.0%	67.1%	71.6%	N/A	65.4%	63.3%	68.9%	65.2%
Child and Adolescent Well-Care Visits	Ethnicity: Unknown	58.7%	63.3%	56.0%	64.2%	59.1%	N/A	54.6%	65.1%	62.2%
Child and Adolescent Well-Care Visits	Race: American Indian and Alaska Native	47.1%	N/A	N/A	N/A	N/A	N/A	50.0%	N/A	55.0%
Child and Adolescent Well-Care Visits	Race: Asian	64.5%	N/A	74.0%	N/A	73.3%	65.9%	71.8%	N/A	69.1%
Child and Adolescent Well-Care Visits	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	68.3%	68.3%
Child and Adolescent Well-Care Visits	Race: Black or African American	58.2%	N/A	64.3%	N/A	67.8%	61.3%	58.8%	65.9%	60.7%
Child and Adolescent Well-Care Visits	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	70.4%	N/A	N/A	N/A	57.9%	N/A	63.9%
Child and Adolescent Well-Care Visits	Race: Some Other Race	63.7%	N/A	N/A	N/A	61.4%	66.2%	N/A	N/A	65.4%
Child and Adolescent Well-Care Visits	Race: Two or More Races	N/A	N/A	N/A	N/A	N/A	N/A	N/A	71.8%	0.0%
Child and Adolescent Well-Care Visits	Race: Unknown	57.4%	63.3%	56.4%	64.2%	57.4%	N/A	64.9%	64.0%	62.0%
Child and Adolescent Well-Care Visits	Race: White	61.0%	63.9%	67.0%	76.0%	58.5%	66.4%	63.1%	68.4%	65.3%
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Hispanic or Latino	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Not Hispanic or Latino	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Unknown	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: American Indian and Alaska Native	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: Asian	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: Black or African American	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: Some Other Race	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: Two or More Races	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: Unknown	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Postpartum Care	Race: White	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Hispanic or Latino	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Not Hispanic or Latino	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Unknown	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%

CHIP-MCO Measures	Race and Ethnicity Stratification	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	CHIP WA
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: American Indian and Alaska Native	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Asian	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Asked but No Answer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Black or African American	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Some Other Race	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Two or More Races	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Unknown	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: White	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%

WA: weighted average; N/A: not applicable, as denominator is less than 30.

Respiratory Conditions

Table 37 is the full set of aggregated data for MY 2022 respiratory conditions measures validated for CHIP.

Table 37: CHIP-MCO Respiratory Conditions Performance Measures

CHIP-MCO Respiratory Conditions Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 Weighted Average Compared to MY 2021
Appropriate Testing for Pharyngitis (Total)	82.4%	81.7%	76.6%	78.0%	87.2%	84.2%	81.9%	81.5%	81.7%	80.9%	Improved
Asthma Medication Ratio (Total)	58.6%	87.8%	83.9%	77.2%	75.7%	83.2%	68.5%	87.0%	77.8%	77.2%	Declined

MY: measurement year.

Utilization

Table 38 is the full set of aggregated data for MY 2022 utilization measures validated for CHIP.

Table 38: CHIP-MCO Utilization Performance Measures

CHIP-MCO Utilization Performance Measures	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	PA Mean	CHIP Weighted Average	MY 2022 CHIP Weighted Average Compared to MY 2021
Ambulatory Care - Emergency Dept Visits/1000 MY (Total)[1]	227.9	203.8	251.2	196.5	227.9	212.0	244.9	264.9	228.6	235.1	Declined
Ambulatory Care - Outpatient Visits/1000 MY (Total)[1]	2364.9	2571.3	3116.2	1966.5	2983.0	2305.1	2774.9	3768.8	2,731.3	2,872.6	Declined
Child and Adolescent Well-Care Visits (Total)	59.1%	63.3%	62.5%	64.3%	59.1%	65.1%	63.3%	66.1%	62.8%	63.4%	Declined
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges/1000 MY (10-19)[2]	1.1	0.4	0.8	0.5	0.4	0.5	0.6	0.9	0.6	N/A	-
Inpatient Utilization - General Hospital/Acute Care - Medicine ALOS (Total)[2]	4.5	3.2	2.5	3.4	2.5	2.7	4.2	2.4	3.2	N/A	-
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges/1000 MY (Total)[2]	4.1	4.3	5.9	3.9	5.1	5.4	3.9	6.5	4.9	N/A	-
Inpatient Utilization - General Hospital/Acute Care - Surgery ALOS (Total)[2]	8.7	N/A	7.5	5.7	N/A	5.4	5.6	4.1	6.1	N/A	-
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges/1000 MY (Total)[2]	2.5	1.3	3.2	2.1	2.9	3.1	1.3	3.1	2.5	N/A	-
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient ALOS (Total)[2]	5.8	3.2	4.2	4.2	4.4	3.6	4.4	2.9	4.1	N/A	-
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges/1000 MY (Total)[2]	7.3	5.8	9.5	6.3	8.2	8.9	5.5	10.1	7.7	N/A	-
Well-Child Visits in the First 30 Months of Life (First 15 Months)	66.0%	66.7%	34.5%	74.1%	26.8%	55.0%	41.3%	76.5%	55.1%	60.7%	Declined
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	78.5%	86.2%	82.7%	89.9%	66.2%	83.5%	86.8%	88.8%	82.8%	84.8%	Declined

[1]HEDIS measure Ambulatory Care calculations changed from member months in MY 2021 to member years in MY 2022. Per NCQA guidance, MY 2021 rates were multiplied by 12 to trend data to MY 2022.

[2]Utilization measures are designed to capture the frequency of certain services provided by the organization. NCQA does not view higher or lower service counts as indicating better or worse performance. A year-to-year comparison is not applicable.

MY: measurement year; ALOS: average length of stay

BH-MCO Performance Measures

PA's HealthChoices BH program does not require BH-MCOs to complete a HEDIS Compliance Audit. BH-MCOs and Primary Contractors are required to calculate PAPMs, which are validated annually by IPRO, to support the MCOs' QAPI Program requirements. For MY 2022, these performance measures were: Follow-up After Hospitalization for Mental Illness (FUH, both HEDIS and PA-specific) and Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA).

In 2018 (MY 2017), in part to better account for the growing population of members 65+ years, OMHSAS changed its benchmarking to the FUH All Ages (6+ years) measure. OMHSAS established a three-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 Statewide BBA report. Due to this change in the goal-setting method, no goals were set for MY 2018. Among the updates in 2019 (MY 2018), NCQA added the following reporting strata for FUH, ages: 6-17, 18-64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are now broken into ages: 6-17, 18-64, and 6 and over (All Ages). HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH MCO to complete and submit an RCA and QIP.

To incentivize improvements in its PA PMs, OMHSAS launched in 2020 a P4P program for the HEDIS FUH All Ages and REA measures that determines payments based on performance with respect to certain benchmarks and to improvement over prior year. BH-MCOs must complete a root cause analysis (RCA) and quality improvement plan (QIP) for each measure not meeting its benchmark. Primary Contractors must similarly produce QIPs for any underperforming indicators. These RCAs and QIPs must also address any ethnic or racial disparities in the rates.

MY 2022 performance measure results are presented in **Table 39** 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 39: BH-MCO Results for 2023 (MY 2022) PAPMs

BH-MCO Performance Measure	CARELON	CBH	CCBH	MBH	PerformCare	BH MMC Average	BH MMC Weighted Average
HEDIS Follow-up After Hospitalization for Mental Illness							
Within 7 Days – Ages 6-17	55.6%	54.4%	55.8%	54.5%	46.9%	53.5%	54.3%
Within 30 Days – Ages 6-17	79.2%	70.8%	78.5%	73.2%	70.6%	74.5%	75.7%
Within 7 Days – Ages 18-64	37.2%	25.1%	36.5%	34.5%	25.0%	31.7%	32.5%
Within 30 Days – Ages 18-64	59.7%	42.1%	57.9%	51.5%	42.7%	50.8%	52.0%
Within 7 Days – Ages 65+	21.3%	19.5%	27.9%	23.4%	26.7%	23.8%	23.8%
Within 30 Days – Ages 65+	31.5%	30.3%	47.0%	29.9%	36.7%	35.1%	36.5%
Within 7 Days – All Ages	41.0%	29.1%	40.6%	38.4%	29.8%	35.8%	36.7%
Within 30 Days – All Ages	63.5%	45.9%	62.2%	55.4%	48.7%	55.1%	56.4%
Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness							

BH-MCO Performance Measure	CARELON	CBH	CCBH	MBH	PerformCare	BH MMC Average	BH MMC Weighted Average
Within 7 Days – All Ages	48.8%	39.5%	46.9%	44.8%	29.8%	41.9%	43.6%
Within 30 Days – All Ages	69.8%	54.5%	65.4%	60.9%	46.9%	59.5%	61.2%
Readmission Within 30 Days of Inpatient Psychiatric Discharge							
Within 30 Days – All Ages	11.4%	16.0%	12.5%	12.8%	12.6%	13.1%	13.1%

Conclusions

For MY 2022, the BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for both the HEDIS FUH 7- and 30-day All-Ages measures were between the HEDIS 33rd and 50th percentiles. Consequently, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for ages 6+ for both 7- and 30-day rates was not achieved.

PA similarly did not achieve its REA performance goal of 11.75% (or lower). Only one of the BH-MCOs, Carelon, had an REA rate at or below 11.75%.

CHC-MCO Performance Measures

Each CHC-MCO underwent a full HEDIS Compliance Audit in 2023. The CHC-MCOs are required by DHS to report part of the set of Medicaid measures, excluding maternal, child, and behavioral health measures, as specified in the *HEDIS MY 2022: Volume 2: Technical Specifications*. CHC-MCOs were also required to report two Medicare measures and the LTSS measure set as specified in HEDIS MY2022 specifications. All the CHC-MCO HEDIS rates are compiled and provided to DHS on an annual basis. IPRO validated all performance measures reported by each MCO for MY 2022 to ensure that the performance measures were implemented to specifications and state reporting requirements (*Title 42 CFR § 438.330(b)(2)*). **Tables 40–53** represent the HEDIS performance for all four CHC-MCOs in 2023, as well as the PA CHC-MCO mean and the CHC MMC weighted average. The PA CHC-MCO mean does not include measures with denominators less than 30. The CHC MMC Weighted Average is a weighted average, which is an average that considers the proportional relevance of each MCO, and therefore includes measures with denominators less than 30.

Regarding the Race and Ethnicity table, direct data for Race and Ethnicity are collected from members' self-identification and is the preferred data source per NCQA. The race and ethnicity stratifications are reported in **Table 49**.

Consumer Assessment of Healthcare Providers and Systems Survey

The CAHPS program includes many products designed to capture consumer and patient perspectives on health care quality. Survey sample frame validation is conducted by NCQA-certified auditors for the Adult Medicaid CAHPS.

For the Adult Medicaid CAHPS, all CHC-MCOs' survey sample frames were deemed valid by the NCQA-certified auditor. The CAHPS program includes many products designed to capture consumer and patient perspectives on health care quality. Survey sample frame validation is conducted by NCQA-certified auditors for the Adult Medicaid CAHPS. CHC-MCO survey results are presented in **Table 77** in **Section VII: Validation of Quality-of-Care Surveys.**

Tables 40–53 summarize the CHC-MCOs' 2023 (MY 2022) HEDIS performance measure results.

Table 40: CHC-MCO Access to/Availability of Care Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 20 to 44 years)	94.3%	89.9%	88.8%	94.2%	91.8%	92.0%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 45 to 64 years)	98.2%	95.8%	93.4%	97.6%	96.3%	96.5%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 65 years and older)	96.9%	95.6%	92.1%	96.9%	95.4%	96.0%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Total)	97.2%	94.8%	92.1%	96.9%	95.2%	95.7%
PA EQR	Annual Adult Dental Visit (Age 21 and older)	21.3%	26.4%	16.9%	21.4%	21.5%	21.5%

HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review.

Table 41: CHC-MCO Behavioral Health Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	82.8%	69.3%	71.6%	83.6%	76.8%	78.5%
HEDIS	Antidepressant Medication Management - Effective Acute Phase Treatment	75.0%	69.6%	78.2%	77.1%	75.0%	74.9%
HEDIS	Antidepressant Medication Management - Effective Continuation Phase Treatment	62.5%	52.8%	67.6%	61.0%	61.0%	59.7%
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	N/A	70.8%	N/A	77.9%	74.4%	75.4%
HEDIS	Diabetes Monitoring for People With Diabetes and Schizophrenia	67.7%	69.3%	60.3%	78.4%	68.9%	72.5%
HEDIS	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	89.5%	85.3%	79.0%	85.6%	84.9%	84.8%
HEDIS	Pharmacotherapy for Opioid Use Disorder (Age 65 years and older)	N/A	N/A	N/A	42.1%	42.1%	42.1%
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 16 to 64 years)	N/A	21.5%	39.3%	38.2%	33.0%	32.6%
HEDIS	Pharmacotherapy for Opioid Use Disorder (Total)	N/A	23.8%	40.3%	38.9%	34.3%	34.1%

HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable, as denominator is less than 30.

Table 42: CHC-MCO Cardiovascular Conditions Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure	77.1%	67.2%	67.2%	73.7%	71.3%	71.0%
HEDIS	Persistence of Beta-Blocker Treatment After a Heart Attack	N/A	91.4%	N/A	95.2%	93.3%	93.8%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Males ages 21 to 75 years)	92.5%	89.5%	83.6%	88.8%	88.6%	88.5%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Females ages 40 to 75 years)	88.4%	88.7%	84.4%	84.2%	86.4%	85.8%

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	90.1%	89.0%	84.0%	86.5%	87.4%	87.1%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Males ages 21 to 75 years)	79.0%	82.9%	85.5%	88.3%	83.9%	86.2%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Females ages 40 to 75 years)	82.1%	82.3%	88.9%	86.0%	84.8%	84.9%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	80.8%	82.5%	87.1%	87.2%	84.4%	85.6%
HEDIS	Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Total)	4.3%	0.8%	1.2%	4.4%	2.7%	2.8%
HEDIS	Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Total)	6.5%	2.5%	2.5%	7.3%	4.7%	5.0%
HEDIS	Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	4.3%	3.0%	4.9%	7.9%	5.0%	5.6%
HEDIS	Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	0.0%	0.4%	2.5%	4.7%	1.9%	2.6%

HEDIS: Healthcare Effectiveness Data and Information Set

Table 43: CHC-MCO Care Coordination Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Advance Care Planning	21.7%	25.2%	41.3%	31.3%	29.9%	30.9%
HEDIS	Transitions of Care - Notification of Inpatient Admission (Total)	15.1%	33.3%	20.7%	45.5%	28.7%	37.9%
HEDIS	Transitions of Care - Receipt of Discharge Information (Total)	15.1%	10.7%	16.1%	40.9%	20.7%	28.8%
HEDIS	Transitions of Care - Patient Engagement After Inpatient Discharge (Total)	82.8%	83.7%	79.1%	89.5%	83.8%	86.4%

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Transitions of Care - Medication Reconciliation Post-Discharge (Total)	68.2%	68.4%	45.0%	76.4%	64.5%	69.8%

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Table 44: CHC-MCO Diabetes Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Blood Pressure Control for Patients With Diabetes	69.3%	61.1%	68.1%	73.7%	68.1%	68.4%
HEDIS	Eye Exam for Patients With Diabetes	60.6%	60.6%	59.9%	71.5%	63.1%	65.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	57.9%	64.2%	60.3%	63.3%	61.4%	62.8%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control (>9.0%)	31.1%	26.8%	32.9%	25.3%	29.0%	27.1%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 18 to 64 years)	39.8%	41.3%	33.5%	45.5%	40.0%	42.1%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 65 to 74 years)	48.7%	54.5%	41.0%	53.0%	49.3%	52.0%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 75 to 85 years)	45.5%	55.6%	51.8%	49.1%	50.5%	51.4%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Total)	41.5%	45.1%	36.3%	47.9%	42.7%	45.1%
HEDIS	Statin Therapy for Patients With Diabetes - Received Statin Therapy	78.3%	80.4%	77.3%	77.9%	78.5%	78.7%
HEDIS	Statin Therapy for Patients With Diabetes - Statin Adherence 80%	82.8%	79.2%	84.6%	87.3%	83.5%	83.9%

HEDIS: Healthcare Effectiveness Data and Information Set

Table 45: CHC-MCO Electronic Clinical Data Systems Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adult Immunization Status - Influenza (Ages 19 to 65 years)	42.9%	32.3%	16.3%	39.6%	32.8%	30.6%
HEDIS	Adult Immunization Status - Td/TDaP (Ages 19 to 65 years)	42.9%	30.7%	13.6%	45.5%	33.2%	34.4%
HEDIS	Adult Immunization Status - Zoster (Ages 50 to 65 years)	12.4%	11.9%	2.7%	17.7%	11.2%	13.5%

HEDIS: Healthcare Effectiveness Data and Information Set

Table 46: CHC-MCO Long-Term Services and Supports Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rates	PHW CHC Rates	UPMC CHC Rates	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Long-Term Services and Supports Comprehensive Assessment and Update - Assessment of Core Elements	95.8%	89.6%	86.5%	96.9%	92.2%	92.1%
HEDIS	Long-Term Services and Supports Comprehensive Assessment and Update - Assessment of Supplemental Elements	94.8%	89.6%	86.5%	96.9%	91.9%	91.9%
HEDIS	Long-Term Services and Supports Comprehensive Care Plan and Update - Care Plan with Core Elements Documented	94.8%	89.6%	80.2%	76.0%	85.2%	84.6%
HEDIS	Long-Term Services and Supports Comprehensive Care Plan and Update - Assessment of Supplemental Elements	94.8%	89.6%	80.2%	76.0%	85.2%	84.6%
HEDIS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge - Reassessment After Inpatient Discharge	30.2%	40.6%	61.5%	55.2%	46.9%	48.9%
HEDIS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge - Reassessment and Care Plan Update After Inpatient Discharge	30.2%	39.6%	57.3%	37.5%	41.1%	38.9%
HEDIS	Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner	81.3%	53.1%	69.8%	64.6%	67.2%	64.6%

HEDIS: Healthcare Effectiveness Data and Information Set

Table 47: CHC-MCO Overuse/Appropriateness Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18 to 64 years)	N/A	63.6%	34.7%	46.8%	48.3%	50.8%
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65 years and older)	N/A	40.0%	N/A	36.4%	38.2%	37.4%
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	41.7%	58.0%	32.8%	43.5%	44.0%	46.3%
HEDIS	Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 18 to 64 years)	6.7%	9.6%	22.1%	14.9%	13.3%	13.5%
HEDIS	Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 65 years and older)	14.3%	12.4%	34.9%	17.0%	19.6%	17.8%
HEDIS	Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Total)	7.7%	10.1%	24.8%	15.6%	14.6%	14.6%
HEDIS	Risk of Continued Opioid Use - At Least 31 Days of Prescription Opioids in a 62-day Period (Ages 18 to 64 years)	5.5%	8.0%	17.6%	9.8%	10.2%	9.9%
HEDIS	Risk of Continued Opioid Use - At Least 31 Days of Prescription Opioids in a 62-day Period (Ages 65 years and older)	7.1%	10.3%	24.7%	8.9%	12.8%	10.7%
HEDIS	Risk of Continued Opioid Use - At Least 31 Days of Prescription Opioids in a 62-day Period (Total)	5.7%	8.4%	19.2%	9.5%	10.7%	10.1%
HEDIS	Use of Imaging Studies for Low Back Pain (Total)	75.7%	81.4%	78.3%	73.5%	77.2%	77.2%
HEDIS	Use of Opioids at High Dosage	11.5%	13.8%	12.8%	8.0%	11.5%	10.0%
HEDIS	Use of Opioids From Multiple Providers - Multiple Pharmacies	0.8%	1.5%	1.0%	2.3%	1.4%	1.9%
HEDIS	Use of Opioids From Multiple Providers - Multiple Prescribers	14.9%	13.8%	16.1%	18.6%	15.9%	17.0%
HEDIS	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	0.0%	0.7%	0.5%	1.3%	0.6%	1.1%

HEDIS: Healthcare Effectiveness Data and Information Set

Table 48: CHC-MCO Prevention and Screening Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Breast Cancer Screening	57.5%	62.5%	47.9%	65.5%	58.3%	62.1%
HEDIS	Care for Older Adults - Functional Status Assessment	55.5%	60.8%	60.8%	71.5%	62.2%	67.1%
HEDIS	Care for Older Adults - Medication Review	99.3%	100.0%	94.7%	89.5%	95.9%	93.1%
HEDIS	Care for Older Adults - Pain Assessment	89.3%	93.7%	86.6%	84.9%	88.6%	87.4%
HEDIS	Cervical Cancer Screening	47.7%	57.2%	40.4%	52.6%	49.5%	52.3%
HEDIS	Chlamydia Screening in Women (Ages 21 to 24 years)	N/A	45.7%	N/A	43.8%	44.7%	44.5%
HEDIS	Chlamydia Screening in Women (Total)	N/A	45.7%	N/A	43.8%	44.7%	44.5%

HEDIS: Healthcare Effectiveness Data and Information Set; Rate N/A: not applicable, as denominator is less than 30.

Table 49: CHC-MCO Race and Ethnicity Stratifications

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure - Ethnicity: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	N/A
HEDIS	Controlling High Blood Pressure - Ethnicity: Hispanic or Latino (Total)	76.6%	73.8%	62.0%	N/A	70.9%	72.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Not Hispanic or Latino (Total)	77.4%	65.4%	67.9%	73.8%	71.1%	70.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Unknown (Total)	N/A	N/A	N/A	N/A	73.3%	68.3%
HEDIS	Controlling High Blood Pressure - Race: American Indian and Alaska Native (Total)	N/A	N/A	N/A	N/A	75.0%	75.0%
HEDIS	Controlling High Blood Pressure - Race: Asian (Total)	75.8%	71.4%	N/A	N/A	73.6%	72.9%
HEDIS	Controlling High Blood Pressure - Race: Asked but No Answer (Total)	77.8%	73.2%	64.4%	N/A	76.1%	76.8%
HEDIS	Controlling High Blood Pressure - Race: Black or African American (Total)	75.0%	64.4%	63.3%	60.0%	65.7%	63.4%
HEDIS	Controlling High Blood Pressure - Race: Native Hawaiian and Other Pacific Islander (Total)	N/A	N/A	N/A	N/A	N/A	N/A
HEDIS	Controlling High Blood Pressure - Race: Some Other Race (Total)	N/A	N/A	N/A	N/A	100.0%	100.0%
HEDIS	Controlling High Blood Pressure - Race: Two or More Races (Total)	N/A	N/A	N/A	N/A	65.0%	65.0%

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure - Race: Unknown (Total)	N/A	N/A	N/A	N/A	81.8%	57.8%
HEDIS	Controlling High Blood Pressure - Race: White (Total)	77.3%	69.1%	71.4%	76.9%	73.7%	75.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	N/A
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Hispanic or Latino (Total)	58.1%	57.5%	59.6%	N/A	53.8%	55.5%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Not Hispanic or Latino (Total)	57.1%	66.6%	60.5%	64.1%	62.1%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Unknown (Total)	N/A	N/A	N/A	N/A	65.3%	58.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: American Indian and Alaska Native (Total)	N/A	N/A	N/A	N/A	100.0%	100.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asian (Total)	60.2%	N/A	N/A	N/A	70.6%	71.8%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asked but No Answer (Total)	58.1%	56.5%	58.5%	N/A	55.8%	55.4%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Black or African American (Total)	51.7%	62.7%	64.8%	53.4%	58.2%	60.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Two or More Races (Total)	N/A	N/A	N/A	N/A	76.9%	76.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Unknown (Total)	N/A	N/A	N/A	N/A	62.6%	42.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: White (Total)	57.8%	69.4%	52.7%	65.3%	61.3%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	N/A

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Hispanic or Latino (Total)	31.0%	27.7%	28.9%	N/A	30.2%	29.2%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Not Hispanic or Latino (Total)	31.5%	26.0%	33.4%	25.1%	29.0%	26.7%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Unknown (Total)	N/A	N/A	N/A	N/A	34.7%	41.1%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: American Indian and Alaska Native (Total)	N/A	N/A	N/A	N/A	0.0%	0.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asian (Total)	28.0%	N/A	N/A	N/A	16.4%	15.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asked but No Answer (Total)	29.0%	26.1%	26.8%	N/A	26.0%	25.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Black or African American (Total)	37.9%	29.6%	31.9%	38.4%	34.4%	32.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Two or More Races (Total)	N/A	N/A	N/A	N/A	19.2%	19.2%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Unknown (Total)	N/A	N/A	N/A	N/A	29.0%	18.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: White (Total)	31.7%	23.6%	37.7%	22.8%	28.9%	25.0%

HEDIS: Healthcare Effectiveness Data and Information Set; Rate N/A: not applicable, as denominator is less than 30.

Table 50: CHC-MCO Respiratory Conditions Performance Measures

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Asthma Medication Ratio (Ages 19 to 50 years)	70.2%	60.5%	62.4%	71.7%	66.2%	65.4%
HEDIS	Asthma Medication Ratio (Ages 51 to 64 years)	63.4%	49.5%	52.9%	68.9%	58.7%	56.1%
HEDIS	Asthma Medication Ratio (Total)	65.7%	53.2%	57.3%	70.2%	61.6%	59.7%

Indicator Source	Indicator Name	ACP CHC Rate	KF CHC Rate	PHW CHC Rate	UPMC CHC Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	90.5%	94.4%	89.6%	89.1%	90.9%	90.9%
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	75.0%	79.4%	77.7%	79.0%	77.8%	78.8%
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.8%	19.2%	20.2%	19.1%	21.3%	19.5%

HEDIS: Healthcare Effectiveness Data and Information Set

Table 51: CHC-MCO Utilization Performance Measures

Indicator Source	Indicator Name	ACP CHC-MCO	KF CHC-MCO	PHW CHC-MCO	UPMC CHC-MCO	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Ambulatory Care - Emergency Dept Visits/1000 MY (Total)	1,073.0	999.0	955.0	967.0	998.6	984.1
HEDIS	Ambulatory Care - Outpatient Visits/1000 MY (Total)	11,980.52	10,108.00	14,007.32	13,492.09	12,397.0	12,338.3
HEDIS	Antibiotic Utilization for Respiratory Conditions (Total)	12.5%	9.3%	12.3%	17.9%	13.0%	13.9%
HEDIS	Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1000 Member Years (Total)	363.0	444.0	364.0	295.0	366.5	365.8

HEDIS: Healthcare Effectiveness Data and Information Set; Rate N/A: not applicable, as denominator is less than 30.

Table 52: CHC-MCO Utilization Performance Measures (FSP)

Indicator Source	Indicator Name	ACP CHC-MCO	KF CHC-MCO	PHW CHC-MCO	UPMC CHC-MCO	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Back Surgery (Females ages 20 to 44 years)	3.1	3.0	2.1	5.1	3.3
HEDIS	Frequency of Selected Procedures - Back Surgery (Females ages 45 to 64 years)	7.5	6.7	7.6	10.8	8.2
HEDIS	Frequency of Selected Procedures - Back Surgery (Males ages 20 to 44 years)	4.7	3.5	1.0	4.1	3.3
HEDIS	Frequency of Selected Procedures - Back Surgery (Males ages 45 to 64 years)	4.4	10.6	4.6	9.4	7.2
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 20 to 44 years)	7.8	4.2	8.4	5.8	6.5

Indicator Source	Indicator Name	ACP CHC-MCO	KF CHC-MCO	PHW CHC-MCO	UPMC CHC-MCO	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 45 to 64 years)	4.8	2.6	2.1	3.8	3.3
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 20 and 44 years)	3.1	1.3	0.0	2.6	1.8
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 45 to 64 years)	0.7	1.9	0.4	1.2	1.1
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 15 to 44 years)	7.8	3.8	3.1	7.7	5.6
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 45 to 64 years)	7.0	3.4	5.5	5.3	5.3
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Males ages 30 to 64 years)	3.9	2.5	4.8	4.2	3.9
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Females ages 15 to 44 years)	0.0	0.4	1.1	0.3	0.5
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Females ages 45 to 64 years)	1.8	0.9	0.0	0.5	0.8
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Males ages 30 to 64 years)	0.6	0.8	1.0	0.3	0.7
HEDIS	Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 15 to 44 years)	0.0	0.8	1.1	2.2	1.0
HEDIS	Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 45 to 64 years)	0.9	1.2	1.7	0.8	1.2
HEDIS	Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 15 to 44 years)	1.6	2.5	3.1	1.9	2.3
HEDIS	Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 45 to 64 years)	0.9	1.0	0.0	0.5	0.6
HEDIS	Frequency of Selected Procedures - Lumpectomy (Females ages 15 to 44 years)	1.6	3.0	1.1	2.2	2.0
HEDIS	Frequency of Selected Procedures - Lumpectomy (Females ages 45 to 64 years)	4.4	3.7	3.1	2.9	3.5
HEDIS	Frequency of Selected Procedures - Mastectomy (Females ages 15 to 44 years)	0.0	0.0	0.0	2.6	0.6
HEDIS	Frequency of Selected Procedures - Mastectomy (Females ages 45 to 64 years)	0.4	1.3	2.1	1.1	1.2

HEDIS: Healthcare Effectiveness Data and Information Set; Rate N/A: not applicable, as denominator is less than 30.

Table 53: CHC-MCO Utilization Performance Measures (PCR)

HEDIS	Indicator Name	ACP CHC-MCO	KF CHC-MCO	PHW CHC-MCO	UPMC CHC-MCO
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Count of Index Stays	149	559	181	412
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Count of Index Stays	198	845	208	556
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Count of Index Stays	441	1,786	437	1,198
HEDIS	Plan All-Cause Readmissions (Ages Total) - Count of Index Stays	788	3,190	826	2,166
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Count of Observed 30 - Day Readmission	19	84	24	55
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Count of Observed 30 - Day Readmission	26	128	31	62
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Count of Observed 30 - Day Readmission	68	275	54	148
HEDIS	Plan All-Cause Readmissions (Ages Total) - Count of Observed 30 - Day Readmission	113	487	109	265
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Count of Expected 30 - Day Readmission	17	64	21	48
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Count of Expected 30 - Day Readmission	25	109	31	67
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Count of Expected 30 - Day Readmission	65	257	63	173
HEDIS	Plan All-Cause Readmissions (Ages Total) - Count of Expected 30 - Day Readmissions	108	432	116	290
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Observed Readmission Rate	12.8	15.0	13.3	13.4
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Observed Readmission Rate	13.1	15.2	14.9	11.2
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Observed Readmission Rate	15.4	15.4	12.4	12.4
HEDIS	Plan All-Cause Readmissions (Ages Total) - Observed Readmission Rate	14.3	15.3	13.2	12.2

HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Expected Readmission Rate	11.7	11.6	12.1	11.9
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Expected Readmission Rate	12.9	13.0	15.0	12.2
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Expected Readmission Rate	14.9	14.4	14.5	14.5
HEDIS	Plan All-Cause Readmissions (Ages Total) - Expected Readmission Rate	13.8	13.6	14.1	13.4
HEDIS	Plan All-Cause Readmissions - (Ages Total) Observed to Expected Readmission Ratio	1.0	1.1	0.9	0.9

HEDIS: Healthcare Effectiveness Data and Information Set.

V. Review of Compliance with Medicaid and CHIP Managed Care Regulations

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

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

Evaluation of PH-MCO Compliance

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

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

IPRO reviewed the elements in the SMART Item List and created a crosswalk to pertinent BBA regulations. The SMART Items did not directly address two categories: Cost Sharing and Effectuation of Reversed Resolutions. Cost Sharing is addressed in the HealthChoices Agreement. Effectuation of Reversed Resolutions is evaluated as part of the most recent NCQA Accreditation review under Utilization Management (UM) Standard 8: Policies for Appeals and UM 9: Appropriate Handling of Appeals. A total of 134 unique SMART Items were identified that were relevant to evaluation of PH-MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS. The SMART Items from compliance review year 2022, 2021, and 2020 provided the information necessary for this assessment.

The crosswalk linked SMART Items to specific provisions of the regulations, where possible. Some items were relevant to more than one provision. The most recently revised CMS protocols included updates to the structure and compliance standards, including which standards are required for compliance review. Under these protocols, there are 14 standards that CMS has designated as required to be subject to

compliance review. Several previously required standards have been deemed by CMS as incorporated into the compliance review through interaction with the new required standards and appear to assess items that are related to the required standards. The compliance evaluation was conducted on the crosswalked regulations for all 14 required standards and remaining related standards that were previously required and continue to be reviewed.

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO's compliance status with regard to the SMART Items. For example, all provisions relating to availability of services are summarized under Availability of Services §438.206. This grouping process was done by referring to CMS's "Regulations Subject to Compliance Review," where specific Medicaid regulations are noted as required for review and corresponding sections are identified and described for each Subpart, particularly D and E. Comprehensive findings for standards that were reviewed either directly through one of the 14 required standards below or indirectly through interaction with Subparts D and E can be found in each MCO's 2023 External Quality Review Report. Each Item was assigned a value of compliant or not compliant in the Item Log submitted by the OMAP. If an Item was not evaluated for a particular MCO, it was assigned a value of not determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category. If all Items were compliant, the MCO was evaluated as compliant. If some were compliant and some were not compliant, the MCO was evaluated as partially compliant. If all Items were not compliant, the MCO was evaluated as not compliant. For categories where Items were not evaluated, under review, or received an approved waiver for MY 2022, results from reviews conducted within the two prior review years (MY 2021 and MY 2020) were evaluated to determine compliance. If no Items were evaluated for a given category and no other source of information was available to determine compliance over the three-year period, a value of not determined was assigned for that specific category.

Tables 54–57 summarize compliance assessments for state and federal regulations across PH-MCOs. Across MCOs, there were no categories determined to be partially- or non-Compliant, signifying that no SMART Items were assigned a value of non-Compliant by DHS. **There are therefore no recommendations related to compliance with state and federal regulations for any PH-MCO for the current review year.**

Table 54: PH-MCO Compliance with Subpart B - State Responsibilities

Subpart B: State Responsibilities	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
Disenrollment Requirements	C	C	C	C	C	C	C	C

Each PH-MCO was compliant for the required Disenrollment Requirements category for MY 2022.

Table 55: PH-MCO Compliance with Subpart C - Enrollee Rights and Protections

Subpart C: Enrollee Rights and Protections	ACP	GEI	HPP	HWC	KF	UHC	UPMC	TOTAL PH MMC
Emergency and Post-Stabilization Services	C	C	C	C	C	C	C	C

Each PH-MCO was compliant for the required Emergency and Post-Stabilization Services category for RY 2022

Table 56: PH-MCO Compliance with Subpart D – MCO, PIHP and PAHP Standards Regulations

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

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

Table 57: PH-MCO Compliance with Subpart E – Quality Measurement and Improvement; External Quality Review Regulations

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

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

Evaluation of CHIP-MCO Compliance

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

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

The SMART Items provide the information necessary for each CHIP-MCO's review. The SMART Items are a comprehensive set of monitoring items that the DHS CHIP staff review on an ongoing basis for each CHIP-MCO. IPRO reviewed the elements in the SMART Item List and created a crosswalk to pertinent BBA regulations. A total of 75 unique SMART Items were identified that were relevant to the evaluation of CHIP-MCO compliance with the BBA regulations. These Items vary in review periodicity from annually, semiannually, quarterly, monthly, or as needed.

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

75 Items were directly associated with a regulation subject to compliance review and were evaluated for the MCO in review year 2022. These items fall under Subpart B: State Responsibilities, Subpart C: Enrollee Rights and Protections, Subpart D: MCO, PIHP and PAHP Standards, and Subpart E: Quality Measurement and Improvement. The general purpose of the regulations included in Subpart B is to ensure that each MCO specifies the reason for an enrollee's disenrollment, and that there is no other reason for disenrollment other than what is permitted under contract (*Title 42 CFR § 438.56 (b))*. The general purpose of the regulations included in Subpart C is to ensure that each MCO had written policies regarding enrollee rights and complies with applicable federal and state laws that pertain to enrollee rights, and that the MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees (*Title 42 CFR § 438.100 (a)–(b)*).The general purpose of the regulations included under Subpart D is to ensure that all services covered under the DHS's CHIP program are available and accessible to MCO enrollees (*Title 42 CFR § 438.206 (a)).* The general purpose of the regulations included under Subpart E is to ensure that each contracting MCO implements and maintains a quality assessment and performance improvement program as required by the State. This includes implementing an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees.

Tables 58–61 summarize compliance assessments for state and federal regulations across CHIP-MCOs. Across MCOs, there were no categories determined to be partially- or non-Compliant, signifying that no SMART Items were assigned a value of non-Compliant by DHS. **There are therefore no recommendations related to compliance with state and federal regulations for any CHIP-MCO for the current review year.**

Table 58: CHIP-MCO Compliance with Subpart B - State Responsibilities

Subpart B: State Responsibilities	ABH	CBC	GEI	HPP	HHK	IBC	UHC	UPMC	TOTAL CHIP
Disenrollment Requirements	C	C	C	C	C	C	C	C	C

Each CHIP-MCO was compliant for the required Disenrollment Requirements category for review year 2022.

Table 59: CHIP-MCO Compliance with Subpart C - Enrollee Rights and Protections

Subpart C: Enrollee Rights and Protections	ABH	CBC	GEI	HPP	HHK	IBC	UHC	UPMC	TOTAL CHIP
Coverage and authorization of services	C	C	C	C	C	C	C	C	C
Enrollee Rights	C	C	C	C	C	C	C	C	C
Emergency and Post-Stabilization Services	NR	NR	NR	NR	NR	NR	NR	NR	NR

NR: Not reviewed

Each CHIP-MCO was compliant for the required Enrollee Rights and Protections categories for review year 2022 in which they were reviewed.

Table 60: CHIP-MCO Compliance with Subpart D – MCO, PIHP and PAHP Standards Regulations

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

[1] Per Centers for Medicare and Medicaid (CMS) guidelines and protocols, this regulation is typically referred to as "Grievance and Appeals Systems." However, to better align with the CHIP reference for 457.1260, it is referred to in this report as "Grievance Systems."

Each CHIP-MCO was compliant for the required MCO, PIHP and PAHP Standards categories for review year 2022.

Table 61: CHIP-MCO Compliance with Subpart E – Quality Measurement and Improvement; External Quality Review Regulations

Subpart E: Quality Measurement and Improvement	ABH	CBC	GEI	HPP	HHK	IBC	UHC	UPMC	TOTAL CHIP
Quality Assessment and Performance Improvement Program (QAPI)	C	C	C	C	C	C	C	C	C

Each CHIP-MCO was compliant for the required Quality Measurement and Improvement category for review year 2022.

Evaluation of BH-MCO Compliance

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

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of BH-MCOs by OMHSAS monitoring staff within the past three review years (RYs 2022, 2021, 2020). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS' SMART Review Application for RY 2022. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year time frame under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year time frame, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's PS&R Agreement is also used. Effective January 1, 2022, Greene County joined BHARP, effectively changing its contract from Carelon to CCBH. Effective July 1, 2022, Delaware County moved its contract from MBH to CCBH. If a county is contracted with more than one BH-MCO in the review period, compliance findings for that county are not included in the BBA reporting for either BH-MCO for a three-year period.

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2022 and entered into the SMART application as of March 2022 for RY 2021. Information captured within SMART informs this report. The application contains a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, SMART 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. Each HealthChoices Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific SMART Substandards that are part of OMHSAS' more rigorous monitoring criteria.

Because OMHSAS' review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The SMART substandards from RY 2022, RY 2021, and RY 2020 provided the information necessary for the 2022 assessment. Those standards not reviewed in RY 2022 were evaluated on their performance based on RY 2021 and/or RY 2020 determinations, or other supporting documentation, if necessary. From time-to-time standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating three-year schedule for all five BH-MCOs. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year time frame under consideration, RAI Substandards were evaluated when none of the SMART Substandards crosswalked to a particular BBA category were reviewed.

The format chosen here to present findings related to BH-MCO compliance with MMC regulations follows the structure described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[19] Under each general section heading are the regulatory categories requiring reporting. Findings for the BH-MCOs are therefore organized under "Standards, including Enrollee Rights and Protections," "Quality Assessment and Performance Improvement (QAPI) Program," and "Grievance

[19] Centers for Medicare & Medicaid Services (CMS). (2023, February). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. CMS External Quality Review (EQR) Protocols (medicaid.gov)

System." Note that under the new CMS review structure, some categories now provide for interaction across Subparts. The standards that are subject to EQR review are contained in *Title 42 CFR § 438*, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E.

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision ("category") and evaluated the Primary Contractors' and BH-MCOs' compliance status with regard to the SMART Substandards. Each substandard was assigned a value of met, partially met, or not met in the SMART 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 SMART substandards linked to each provision. If all substandard items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as not compliant. If no crosswalked items were evaluated for a given provision, and no other source of information was available to determine compliance, a value of not applicable (N/A) was assigned for that provision. A value of null was assigned to a provision when none of the existing SMART 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. **Tables 62–64** summarize compliance assessments across MCOs.

Table 62: BH-MCO Compliance with Standards, Including Enrollee Rights and Protections

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

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

Table 63: BH-MCO Compliance with Quality Assessment and Performance Improvement Program

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

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

Table 64: BH-MCO Compliance with Grievance System

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

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

- Overall, in MY 2022 PA's BH program was partially compliant across all three CMS sections of MMC regulations.
- PA BH-MCOs were fully compliant with the following categories: Confidentiality, Disenrollment, Emergency and post-stabilization services, Enrollee rights and protections, and Subcontractual relationships and delegation.
- IPRO recommends OMHSAS add an explicit check, in its compliance review of MCO disenrollment policies and procedures, that the MCO has in place protocols for handling and directing member inquiries about voluntary disenrollment to the appropriate state agency.
- MBH was the one MCO fully compliant with all categories within Standards, including Enrollee Rights and Protections section.
- All PA BH-MCOs were partially compliant with the standards covering Grievance and appeal systems.

Evaluation of CHC-MCO Compliance

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

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

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

The EQRO utilizes the SMART database findings as of the effective review year, per the following: the CHC Agreement, additional monitoring activities outlined by the Department, and the most recent NCQA Accreditation Survey for each CHC-MCO. Historically, regulatory requirements were grouped to corresponding BBA regulation subparts based on the Department's on-site review findings. Beginning in 2021, findings are reported by the EQRO using the SMART database completed by the Department's staff. The SMART items provide the information necessary for this review. The SMART items and their associated review findings for this year are maintained in a database. The SMART database has been maintained internally at the Department starting with (RY) 2020 and will continue going forward for future review years. The EQRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 80 items were identified that were relevant to evaluation of CHC-MCO compliance with the BBA regulations.

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. The crosswalk links SMART items to specific provisions of the regulations, where possible.

Items linked to each standard designated in the protocols as subject to compliance review were included either directly through one of the 11 required standards below, as presented in the below table, or indirectly through interaction with Subparts D and E.

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

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

Categories determined to be partially- or non-Compliant are indicated where applicable in **Tables 65–68**, and the SMART Items that were assigned a value of non-Compliant by the Department within those categories are noted. For the CHC-MCOs, there were no categories determined to be partially- or non-Compliant, signifying that the associated SMART Items were not assigned a value of non-Compliant by the Department.

Table 65: CHC-MCO Compliance with Subpart B - State Responsibilities

Subpart B: State Responsibilities	ACP	KF	PHW	UPMC	TOTAL CHC MMC
Disenrollment Requirements	C	C	C	C	C

Table 66: CHC-MCO Compliance with Subpart C - Enrollee Rights and Protections

Subpart C: Enrollee Rights and Protections	ACP	KF	PHW	UPMC	TOTAL CHC MMC
Enrollee Rights	C	C	C	C	C
Emergency and Post-Stabilization Services	C	C	C	C	C

Table 67: CHC-MCO Compliance with Subpart D - MCO, PIHP, and PAHP Standards Regulations

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

Table 68: CHC-MCO Compliance with Subpart E – Quality Measurement and Improvement; External Quality Review Regulations

Subpart E: Quality Measurement and Improvement	ACP	KF	PHW	UPMC	TOTAL CHC MMC
Quality Assessment and Performance Improvement Program (QAPI)	C	C	C	C	C

- Overall, the CHC-MCOs were found to be compliant across all applicable items directly associated with CFR Categories for Subparts B, C, and E that were subject to review in 2023.
- ACP, KF, and PHW were determined to be partially compliant with coordination and continuity of care. As it relates to the partially compliant CFR Subpart D, the recommendation is for the MCOs to facilitate a seamless transition between CHC-MCOs by improving transfer of information and records. There are no other recommendations related to compliance with CFR Categories for Subparts B, C, D and E for the MCO for the current review year.
- ACP and KF were determined to be partially compliant with health information systems. As it relates to the partially compliant CFR Subpart D, the recommendation is for the MCOs to facilitate a seamless transition between CHC-MCOs by improving transfer of information in their systems. There are no other recommendations related to compliance with CFR Categories for Subparts B, C, D and E for the MCOs for the current review year.

VI. Validation of Network Adequacy

Title 42 CFR § 438.68(a) requires states that contract with an MCO to deliver services must develop and enforce network adequacy standards consistent with the CFR. States have flexibility in the types of quantitative standards they choose to use. PA DHS chose to develop network adequacy standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology (ob/gyn), adult and pediatric BH (for mental health and substance use disorder [SUD]), adult and pediatric specialists, hospitals, pediatric and general dentists, and long-term services and support (LTSS), per *Title 42 CFR § 438.68(b)*. PA DHS has developed access standards based on the requirements outlined at *Title 42 CFR § 438.68(c)*. These access standards are described in the applicable ODP, OLTL, OMAP and OHMSAS agreements and CHIP Procedures Handbook, Section 21.9.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, PA contracted with IPRO to perform the validation of network adequacy for PA MCOs. In February 2023, CMS released updates to the EQR protocols, including the newly developed network adequacy validation protocol. The six protocol activities related to planning, analysis, and reporting are outlined in **Table 69**.

Table 69: Network Adequacy Validation Activities[20]

Activity[1]	Standard	Category
1	Define the scope of the validation.	Planning
2	Identify data sources for validation.	Planning
3	Review information systems.	Analysis
4	Validate network adequacy.	Analysis
5	Communicate preliminary findings to MCO.	Reporting
6	Submit findings to the state.	Reporting

[1] At the time of this report, only activities 1 and 2 were conducted for measurement year 2022.
MCO: managed care organization

Starting February 2024, the EQRO must conduct validation activities and report those results in the ATR published in April 2025. While validation activities were not mandatory for 2023, PA identified activities 1 and 2 as valuable sources of information to highlight the strengths and opportunities of PA's network adequacy standards, indicators, and data collection processes. Additionally, engaging in steps 1 and 2 in 2023 better prepared IPRO for the full set of validation activities mandated for 2024.

Technical Methods of Data Collection and Analysis

IPRO gathered information from PA's MCQS to identify data sources for validation and to define the scope of validation activities that will be conducted in 2024.

Description of Data Obtained

Network adequacy standards are quantitative parameters that states establish to set expectations for contracted MCOs' provider networks. Network adequacy indicators are metrics used to measure adherence to network adequacy standards and to determine plan compliance with state network adequacy standards. The PA-established access, distance, and time standards are presented by the two PA geographical regions: urban and rural. **Tables 70–72** display the PA provider network standards that were applicable in 2023, as outlined in the PA MCQS.[21] A checkmark indicates that the standard is applicable to the specific DHS program office.

[20] Centers for Medicare & Medicaid Services (CMS). (2023, March). Managed Care External Quality Review: Network Adequacy Validation Protocol (Technical Assistance Resource). Managed Care External Quality Review: Network Adequacy Validation Protocol (medicaid.gov)

[21] PA DHS. (2023). *Medical Assistance and Children's Health Insurance Program managed care quality strategy*. 45-49. 2023 Medical Assistance Quality Assistance Strategy for Pennsylvania (pa.gov).

Table 70: Pennsylvania Network Access Standards for Time and Distance

PA Time/Distance Standards	CHIP	ODP	OLTL	OMAP	OMHSAS
Adult Primary Care	✓	✓	✓	✓	N/A
Pediatric Primary Care	✓	N/A	N/A	✓	N/A
Certified Nurse Midwives and Certified Registered Nurse Practitioners	N/A	N/A	✓	✓	N/A
Ambulatory Services (OB/GYN and LTSS standards under ODP only)	N/A	✓	N/A	N/A	✓
Hospitals	✓	N/A	✓	✓	N/A
Inpatient and Residential Services (LTSS standards under ODP and OLTL only)	N/A	✓	✓	N/A	✓
Federally Qualified Health Center (FQHC)	N/A	N/A	✓	N/A	✓
Rehabilitation Facilities	✓	N/A	✓	✓	N/A
Rural Health Clinic (RHC)	N/A	N/A	✓	N/A	N/A
Specifically Identified Specialists	✓	N/A	✓	✓	✓

PA: Pennsylvania; CHIP: Children's Health Insurance Program; ODP: Office of Developmental Programs; OLTL: Office of Long-Term Living; OMAP: Office of Medical Assistance Programs; OMHSAS: Office of Mental Health and Substance Abuse Services; N/A: not applicable; OB/GYN: obstetrics/gynecology; LTSS: long-term care services and supports

Table 71: Pennsylvania Network Access Standards for Required Minimum for Choice of Providers

PA Required Minimum for Choice of Providers Standards	CHIP	ODP	OLTL	OMAP	OMHSAS
Adult Primary Care	2	2	2	2	N/A
Pediatric Primary Care	2	N/A	N/A	2	N/A
BH Providers	2	2	N/A	N/A	2
LTSS Providers	N/A	2	2	N/A	N/A
Hospitals	1	NA	1	1	N/A
Mental Health In-Patient Hospitals	N/A	N/A	N/A	N/A	1
Rehabilitation Facilities	2	N/A	2	2	N/A
Dental Care	2	N/A	2	2	N/A
FQHCs and RHCs	N/A	N/A	All	All	All
Specifically Identified Specialists	2	2	2	2	N/A

PA: Pennsylvania; CHIP: Children's Health Insurance Program; ODP: Office of Developmental Programs; OLTL: Office of Long-Term Living; OMAP: Office of Medical Assistance Programs; OMHSAS: Office of Mental Health and Substance Abuse Services; BH: behavioral health; N/A: not applicable; LTSS: long-term care services and supports; FQHC: federally qualified health center; RHC: rural health clinic

Table 72: Pennsylvania Network Access Standards for Appointment Wait Times

PA Appointment Wait Time Standards	CHIP	ODP	OLTL	OMAP	OMHSAS
Emergency Medical Services	✓	✓	✓	✓	✓
Urgent Medical Services	✓	✓	✓	✓	✓
Routine Care	✓	✓	✓	✓	✓
Initial Assessment and Care	✓	✓	✓	✓	✓

PA: Pennsylvania; CHIP: Children's Health Insurance Program; ODP: Office of Developmental Programs; OLTL: Office of Long-Term Living; OMAP: Office of Medical Assistance Programs; OMHSAS: Office of Mental Health and Substance Abuse Services.

Conclusions and Comparative Findings

Network standards and access-related requirements can be categorized into four types: (1) time and distance standards; (2) timely access standards, such as appointment wait times; (3) provider-to-enrollee ratios; and (4) other standards, such as those related to physical and cultural accessibility.[22] All four types are important to ensure that Medicaid and CHIP beneficiaries can receive timely and adequate access to services.[22]

PA has established network adequacy standards, indicators, and data sources for all four network adequacy categories that are tailored to PA HealthChoices and CHIP members and services covered by the program and adapted to PA's geographic and provider context.

[22] Lipson, D.J., Libersky, J., Bradley, K., Lewis, C., Siegwarth, A.W., and Lester, R. (2017). *Promoting access in Medicaid and CHIP managed care: A toolkit for ensuring provider network adequacy and service availability*. Division of Managed Care Plans, Center for Medicaid and CHIP Services, CMS, U.S. Department of Health and Human Services. Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability (nv.gov).

VII. Validation of Quality-of-Care Surveys

Objectives

Title 42 CFR § 438.358(c)(2) establishes that for each MCO, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *Title 42 CFR §* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual EQR.

The PA DHS requires MCOs to sponsor a member experience survey annually. The goal of the survey is to get feedback from these members about how they view the health care services they receive. DHS uses results from the survey to determine variation in member satisfaction among the MCOs. Due to the BH carve-out in PA, BH-MCOs are exempt from this requirement.

The overall objective of the CAHPS survey is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of care provided.

Each MCO independently contracted with a certified CAHPS vendor to administer the adult and child surveys, as applicable, for MY 2022.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected were as follows:

- PH-MCOs: CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey;
- CHIP-MCOs: CAHPS 5.1H Child Medicaid Health Plan Survey (without the chronic conditions measurement set); and
- CHC-MCOs: CAHPS 5.1H Adult Medicaid Health Plan Survey.

HEDIS specifications require that the MCOs provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the MCOs included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2022, who were continuously enrolled for at least five of the last six months of 2022, and who were currently enrolled in the MCO.

Results were calculated in accordance with HEDIS specifications for survey measures. According to HEDIS specifications, results for the adult and child populations were reported separately, and no weighting or case-mix adjustment was performed on the results.

For the global ratings, composite measures, composite items, and individual item measures, the scores were calculated using a 100-point scale. Responses were classified into response categories. **Table 73** displays these categories and the measures by which these response categories are used.

Table 73: CAHPS Adult and Child Categories and Response Options

Category/Measure	Response Options
Composite measures	
• Getting Needed Care • Getting Care Quickly • How Well Doctors Communicate • Customer Service	Never, sometimes, usually, always (Top-level performance is considered responses of "usually" or "always.")
Global rating measures	
• Rating of All Health Care • Rating of Personal Doctor • Rating of Specialist Talked to Most Often • Rating of Health Plan • Rating of Treatment or Counseling	0–10 scale (Top-level performance is considered scores of "8" or "9" or "10.")

CAHPS: Consumer Assessment of Healthcare Providers and Systems

To assess MCO performance, IPRO compared MCO scores to national Medicaid performance reported in the 2023 Quality Compass® (MY 2022) for all lines of business that reported MY 2022 CAHPS data to NCQA. This comparison was not available for the CHC-MCO population due to the unique nature of the populations served.

Description of Data Obtained

For each MCO, IPRO received a copy of the final MY 2022 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as MCO-level results and analyses.

PH-MCO Conclusions and Comparative Findings

As referenced in **Section IV: Validation of Performance Measures, Table 74** and **Table 75** provide the survey results of four composite questions by two specific categories for each PH-MCO and the MY 2022 MMC weighted average. The composite questions target the MCOs' performance strengths as well as opportunities for improvement.

Table 74: PH-MCO CAHPS MY 2022 Adult Survey Results

CAHPS Measure	ACP	GEI	HPP	HWC	KF	UHC	UPMC	MY 2022 MMC WA
Your health plan								
Satisfaction with Adult's Health Plan (Rating of 8–10)	78.99%	83.66%	86.15%	79.67%	80.33%	76.43%	84.62%	81.33%
Getting Needed Information (Usually or Always)	81.40%	84.48%	86.36%	79.44%	82.98%	86.79%	89.43%	84.33%
Your health care in the last six months								
Satisfaction with Health Care (Rating of 8–10)	72.32%	75.52%	83.52%	76.32%	84.52%	82.80%	79.41%	78.54%
Appointment for Routine Care When Needed (Usually or Always)	83.23%	84.38%	77.17%	81.77%	81.01%	72.86%	83.33%	81.49%

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid managed care; WA: weighted average.

Table 75: PH-MCO CAHPS MY 2022 Child Survey Results

CAHPS Measure	ACP	GEI	HPP	HWC	KF	UHC	UPMC	MY 2022 MMC WA
Your child's health plan								
Satisfaction with Health Child's Health Plan (Rating of 8–10)	86.77%	86.60%	91.30%	89.98%	89.86%	86.23%	88.73%	88.80%
Information or Help from Customer Service (Usually or Always)	85.51%	90.20%	92.06%	82.55%	83.33%	65.31%	80.77%	83.06%
Your health care in the last six months								
Satisfaction with Health Care (Rating of 8–10)	86.41%	87.14%	88.60%	88.37%	84.48%	87.76%	86.49%	87.10%
Appointment for Routine Care When Needed (Usually or Always)	87.08%	87.12%	86.32%	85.71%	78.03%	78.22%	88.89%	84.91%

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid managed care; WA: weighted average.

CHIP-MCO Conclusions and Comparative Findings

As referenced in **Section IV: Validation of Performance Measures, Table 76** provides the survey results of four composite questions by two specific categories for each CHIP-MCO and the MY 2022 CHIP weighted average. The composite questions target the MCOs' performance strengths as well as opportunities for improvement.

Table 76: CHIP-MCO CAHPS MY 2022 Child Survey Results

CAHPS Measure	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	MY 2022 CHIP WA
Your child's health plan									
Satisfaction with your child's current personal doctor (Rating of 8–10)	88.11%	92.78%	87.50%	85.37%	87.21%	89.00%	90.72%	88.79%	88.68%
Satisfaction with specialist (Rating of 8–10)	87.21%	93.55%	88.57%	82.26%	83.33%	87.50%	93.33%	85.07%	87.60%
Satisfaction with health plan (Rating of 8–10) (Satisfaction with child's plan)	77.16%	88.41%	85.30%	87.33%	83.50%	86.27%	82.81%	89.07%	84.98%
Satisfaction with child's health care (Rating of 8–10)	84.21%	90.51%	86.67%	89.68%	89.34%	87.50%	87.12%	87.20%	87.78%

CAHPS Measure	ABH	CBC	GEI	HHK	HPP	IBC	UHC	UPMC	MY 2022 CHIP WA
Your health care in the last six months									
Received care for child's mental health from any provider? (Usually or Always)	14.12%	9.80%	8.18%	14.22%	7.14%	8.56%	11.65%	15.13%	11.10%
Easy to get needed mental health care? (Usually or Always)	11.75%	7.58%	5.28%	9.63%	6.12%	4.65%	9.85%	11.25%	8.27%
Provider you would contact for mental health services? (PCP)	65.24%	64.00%	63.53%	67.92%	63.08%	68.20%	62.14%	64.88%	64.87%
Child's overall mental or emotional health? (Very good or Excellent)	78.38%	78.20%	75.89%	75.77%	69.71%	74.36%	74.52%	75.40%	75.28%

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; WA: weighted average; PCP: primary care provider.

CHC-MCO Conclusions and Comparative Findings

As referenced in **Section IV: Validation of Performance Measures, Table 77** provides the survey results of the CAHPS data broken out by three key areas: Rating of Access to Care, Ratings of Health Plans, and Ratings of Personal Doctor. Further stratification is provided for the aligned versus the unaligned population. The aligned population includes Medicaid-CHC only or CHC and an aligned D-SNP. The unaligned population includes CHC and fee-for-service Medicare or other Medicare Advantage product than an aligned D-SNP. The composite questions target the MCOs' performance strengths as well as opportunities for improvement.

Table 77: CHC-MCO CAHPS MY 2022 Adult Survey Results

CAHPS Measure	ACP - Aligned	ACP - Unaligned	KF – Aligned	KF - Unaligned	PHW - Aligned	PHW - Unaligned	UPMC - Aligned	UPMC - Unaligned
Your health plan								
Satisfaction with Adult's Health Plan (Rating of 8–10)	78.07%	84.35%	82.56%	86.51%	78.78%	86.49%	90.49%	86.22%
Customer Service (Usually or Always)	85.18%	92.80%	92.39%	89.68%	89.86%	91.75%	93.14%	94.38%
Your access to care in last 12 months								
Getting Needed Care Composite (Usually or Always)	81.80%	87.67%	85.78%	86.55%	84.10%	86.86%	88.04%	88.31%
Getting Care Quickly Composite (Usually or Always)	84.35%	86.27%	85.35%	86.95%	86.74%	87.21%	86.86%	86.95%
Your personal doctor								
Satisfaction with Personal Doctor (Rating of 8-10)	86.22%	87.02%	87.11%	84.89%	85.17%	87.74%	85.68%	85.82%
Doctor Informed/Up to Date on Care (Usually or Always)	89.22%	90.00%	89.19%	88.57%	89.27%	92.89%	86.61%	94.59%
How Well Doctors Communicate Composite (Usually or Always)	95.07%	94.82%	92.61%	94.10%	94.15%	95.21%	95.09%	93.73%
Hard to Find Doctor Who Speaks Your Language (Never or Sometimes)	37.07%	57.58%	42.75%	50.00%	55.43%	49.41%	57.30%	71.94%
Hard to Find Doctor Who Understands Your Culture (Never or Sometimes)	66.36%	64.77%	64.52%	75.32%	65.96%	78.05%	67.14%	71.01%

VIII. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement (QI) made by the EQRO during the previous year's EQR." The tables in this section display each MCO's progress related to the *2022 External Quality Review Report*, as well as IPRO's assessment of the MCO's response.

PH Response to Previous EQR Recommendations

Tables 78–84 display the PH-MCO responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

Table 78: PH-MCO – ACP Response to Previous EQR Recommendations

Recommendation for ACP	IPRO Assessment of MCO Response[1]
Improve Developmental Screening in the First Three Years of Life – 1 year	Partially addressed
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18–64 years: ED visits for AOD abuse or dependence, follow-up within 30 days)	Partially addressed
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Remains an opportunity for improvement
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Ages 16–20 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Ages 21–24 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Total)	Remains an opportunity for improvement
Improve Prenatal Screening for Smoking	Addressed
Improve Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	Addressed
Improve Prenatal Counseling for Environmental Tobacco Smoke Exposure	Partially addressed
Improve Appropriate Testing for Pharyngitis (Ages 3–17 years)	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years)	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	Addressed
Improve Kidney Health Evaluation for Patients with Diabetes (Ages 18–64 years)	Addressed
Improve Kidney Health Evaluation for Patients with Diabetes (Ages 65–74 years)	Addressed
Improve Kidney Health Evaluation for Patients with Diabetes (Ages 75–85 years)	Partially addressed
Improve Kidney Health Evaluation for Patients with Diabetes (Total)	Addressed
Improve Use of Pharmacotherapy for Opioid Use Disorder (Total)	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

Table 79: PH-MCO – GEI Response to Previous EQR Recommendations

Recommendation for GEI	IPRO Assessment of MCO Response[1]
Improve Childhood Immunizations Status (Combination 10)	Partially addressed
Improve Body Mass Index: Percentile (Ages 12–17 years)	Partially addressed
Improve Body Mass Index: Percentile (Total)	Partially addressed
Improve Counseling for Nutrition (Ages 12–17 years)	Addressed
Improve Counseling for Nutrition (Total)	Addressed
Improve Counseling for Physical Activity (Ages 12–17 years)	Addressed
Improve Developmental Screening in the First Three Years of Life – Total	Remains an opportunity for improvement
Improve Developmental Screening in the First Three Years of Life – 1 year	Remains an opportunity for improvement
Improve Developmental Screening in the First Three Years of Life – 2 years	Remains an opportunity for improvement
Improve Developmental Screening in the First Three Years of Life – 3 years	Remains an opportunity for improvement
Improve Annual Dental Visit (Ages 2–20 years)	Addressed
Improve Annual Dental Visits for Members with Developmental Disabilities (Ages 2–20 years)	Addressed
Improve Cervical Cancer Screening (Ages 21–64 years)	Addressed
Improve Chlamydia Screening in Women (Ages 16–20 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Ages 21–24 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Total)	Remains an opportunity for improvement
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 15–20 years)	Partially addressed
Improve Contraceptive Care for Postpartum Women: LARC – 60 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 21 to 44 years)	Remains an opportunity for improvement
Improve Prenatal Smoking Cessation	Remains an opportunity for improvement
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years)	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	Partially addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older) Admissions per 100,000 member months	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

EQR: external quality review; MCO: managed care organization; LARC: long-acting reversible contraception.

Table 80: PH-MCO – HPP Response to Previous EQR Recommendations

Recommendation for HPP	IPRO Assessment of MCO Response[1]
Improve Body Mass Index: Percentile (Ages 3–11 years)	Partially addressed
Improve Body Mass Index: Percentile (Ages 12–17 years)	Partially addressed
Improve Body Mass Index: Percentile (Total)	Partially addressed
Improve Counseling for Nutrition (Ages 3–11 years)	Partially addressed
Improve Counseling for Nutrition (Total)	Partially addressed
Improve Follow-Up Care for Children Prescribed ADHD Medication (BH Enhanced) – Initiation Phase	Addressed
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years – ED visits for AOD abuse or dependence, follow-up within 7 days)	Partially addressed
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Addressed
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Addressed
Improve Oral Evaluation, Dental Services (Ages < 1–20 years)	Addressed
Improve Topical Fluoride for Children (Dental Services)	Addressed
Improve Chlamydia Screening in Women (Ages 16–20 years)	Partially addressed
Improve Chlamydia Screening in Women (Ages 21–24 years)	Partially addressed
Improve Chlamydia Screening in Women (Total)	Partially addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC – 60 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 21–44 years)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 21–44 years)	Partially addressed
Improve Prenatal Screening for Smoking	Remains an opportunity for improvement
Improve Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	Remains an opportunity for improvement
Improve Prenatal Screening for Environmental Tobacco Smoke Exposure	Addressed
Improve Prenatal Screening for Depression	Partially addressed
Improve Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years)	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18–64 years)	Addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	Addressed
Improve Diabetes Short-Term Complications Admission Rate (Ages 18–64 years) Admissions per 100,000 member months	Partially addressed
Improve Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Partially addressed
Improve Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 18–64 Years of Age)	Partially addressed
Improve Use of Opioids at High Dosage	Addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

EQR: external quality review; MCO: managed care organization; ADHD: attention deficit hyperactivity disorder; BH: behavioral health; ED: emergency department; AOD: alcohol and other drug; LARC: long-acting reversible contraception; CHIPRA: Children's Health Insurance Program Reauthorization Act.

Table 81: PH-MCO – HWC Response to Previous EQR Recommendations

Recommendation for HWC	IPRO Assessment of MCO Response[1]
Improve Topical Fluoride for Children (Dental/Oral Health Services)	Partially addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 15–20 years)	Partially addressed
Improve Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 15–20 years)	Remains an opportunity for improvement
Improve Contraceptive Care for Postpartum Women: LARC – 60 days (Ages 15–20 years)	Addressed
Improve Prenatal Screening for Smoking	Partially addressed
Improve Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	Partially addressed
Improve Prenatal Screening for Environmental Tobacco Smoke Exposure	Partially addressed
Improve Prenatal Screening for Depression	Partially addressed
Improve Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	Partially addressed
Improve Postpartum Screening for Depression	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years)	Addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40–64 years) Admissions per 100,000 member months	Partially addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+ years) Admissions per 100,000 member months	Partially addressed
Improve Diabetes Short-Term Complications Admission Rate (Ages 18–64 years) Admissions per 100,000 member months	Partially addressed
Improve Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Partially addressed
Improve Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 18–64 Years of Age)	Partially addressed
Improve Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Total)	Partially addressed
Improve Heart Failure Admission Rate (Ages 18–64 years) Admissions per 100,000 member months	Partially addressed
Improve Heart Failure Admission Rate (Ages 65+ years) Admissions per 100,000 member months	Partially addressed
Improve Heart Failure Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
EQR: external quality review; MCO: managed care organization; LARC: long-acting, reversible contraception; CHIPRA: Children's Health Insurance Program Reauthorization Act.

Table 82: PH-MCO – KF Response to Previous EQR Recommendations

Recommendation for KF	IPRO Assessment of MCO Response[1]
Improve Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44 years)	Remains an opportunity for improvement
Improve Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12–17 years)	Remains an opportunity for improvement
Improve Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1–17 years)	Remains an opportunity for improvement
Improve Well-Child Visits in the First 30 Months of Life (Ages 15 months ≥ 6 Visits)	Partially addressed
Improve Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	Remains an opportunity for improvement
Improve Follow-Up Care for Children Prescribed ADHD Medication (BH Enhanced) – Initiation Phase	Remains an opportunity for improvement
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years – ED visits for mental illness, follow-up within 7 days)	Remains an opportunity for improvement
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years – ED visits for mental illness, follow-up within 30 days)	Remains an opportunity for improvement
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Remains an opportunity for improvement
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Remains an opportunity for improvement
Improve Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15–20 years)	Remains an opportunity for improvement
Improve Prenatal Counseling for Smoking	Partially addressed
Improve Prenatal Counseling for Environmental Tobacco Smoke Exposure	Addressed
Improve Prenatal Screening Positive for Depression	Partially addressed
Improve Prenatal Counseling for Depression	Partially addressed
Improve Appropriate Testing for Pharyngitis (Ages 18–64 years)	Addressed
Improve Appropriate Testing for Pharyngitis (Total)	Partially addressed
Improve Appropriate Treatment for Upper Respiratory Infection (Ages 18–64 years)	Remains an opportunity for improvement
Improve Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	Addressed
Improve Asthma in Younger Adults Admission Rate (Ages 2–17 years) Admissions per 100,000 member months	Addressed
Improve Asthma in Younger Adults Admission Rate (Ages 18–39 years) Admissions per 100,000 member months	Partially addressed
Improve Asthma in Younger Adults Admission Rate (Total Ages 2–39 years) Admissions per 100,000 member months	Addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40–64 years) Admissions per 100,000 member months	Partially addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+ years) Admissions per 100,000 member months	Partially addressed
Improve HbA1c Poor Control (> 9.0%)	Measure retired
Improve Blood Pressure Controlled < 140/90 mm Hg	Measure retired
Improve Diabetes Short-Term Complications Admission Rate (Ages 18–64 years) Admissions per 100,000 member months	Partially addressed
Improve Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Partially addressed
Improve Controlling High Blood Pressure (Total Rate)	Measure retired

Recommendation for KF	IPRO Assessment of MCO Response[1]
Improve Heart Failure Admission Rate (Ages 18–64 years) Admissions per 100,000 member months	Partially addressed
Improve Heart Failure Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Partially addressed
Improve Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Ages 40–75 years (Female)	Addressed
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1–11 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12–17 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Ages 1–17 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Ages 1–17 years)	Partially addressed
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 1–11 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 12–17 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Ages 1–17 years)	Remains an opportunity for improvement
Improve Use of Opioids at High Dosage	Partially addressed
Improve Concurrent Use of Opioids and Benzodiazepines (Total Ages 18 years and older)	Addressed
Improve Use of Pharmacotherapy for Opioid Use Disorder (Total)	Addressed
Improve Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)	Addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
EQR: external quality review; MCO: managed care organization; ADHD: attention deficit hyperactivity disorder; BH: behavioral health; ED: emergency department; HbA1c: hemoglobin A1c.

Table 83: PH-MCO – UHC Response to Previous EQR Recommendations

Recommendation for UHC	IPRO Assessment of MCO Response[1]
Improve Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44 years)	Remains an opportunity for improvement
Improve Adults' Access to Preventive/Ambulatory Health Services (Ages 45–64 years)	Remains an opportunity for improvement
Improve Child and Adolescent Well-Care Visits (Ages 18–21 years)	Addressed
Improve Childhood Immunizations Status (Combination 3)	Addressed
Improve Lead Screening in Children (Age 2 years)	Addressed
Improve Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	Addressed
Improve Follow-Up Care for Children Prescribed ADHD Medication (BH Enhanced) – Initiation Phase	Addressed
Improve Follow-Up Care for Children Prescribed ADHD Medication (BH Enhanced) – Continuation Phase	Partially addressed
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years – ED visits for mental illness, follow-up within 7 days)	Remains an opportunity for improvement

Recommendation for UHC	IPRO Assessment of MCO Response[1]
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years – ED visits for mental illness, follow-up within 30 days)	Remains an opportunity for improvement
Improve Oral Evaluation, Dental Services (Ages < 1–20 years)	Addressed
Improve Topical Fluoride for Children (Dental Services)	Addressed
Improve Breast Cancer Screening (Ages 50–74 years)	Partially addressed
Improve Cervical Cancer Screening (Ages 21–64 years)	Partially addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 15–20 years)	Addressed
Improve Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	Remains an opportunity for improvement
Improve Asthma Medication Ratio (Ages 5–11 years)	Remains an opportunity for improvement
Improve Asthma Medication Ratio (Ages 12–18 years)	Remains an opportunity for improvement
Improve Asthma Medication Ratio (Ages 19–50 years)	Remains an opportunity for improvement
Improve Asthma Medication Ratio (Total)	Remains an opportunity for improvement
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40–64 years) Admissions per 100,000 member months	Partially addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+ years) Admissions per 100,000 member months	Partially addressed
Improve Retinal Eye Exam	Measure retired
Improve Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Ages 21–75 years (Male)	Partially addressed
Improve Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate	Partially addressed
Improve Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
EQR: external quality review; MCO: managed care organization; ADHD: attention deficit hyperactivity disorder; BH: behavioral health; ED: emergency department; COPD: chronic obstructive pulmonary disease.

Table 84: PH-MCO – UPMC Response to Previous EQR Recommendations

Recommendation for UPMC	IPRO Assessment of MCO Response[1]
Improve Body Mass Index: Percentile (Ages 3–11 years)	Partially addressed
Improve Body Mass Index: Percentile (Ages 12–17 years)	Partially addressed
Improve Body Mass Index: Percentile (Total)	Partially addressed
Improve Counseling for Nutrition (Ages 3–11 years)	Partially addressed
Improve Counseling for Nutrition (Ages 12–17 years)	Partially addressed
Improve Counseling for Nutrition (Total)	Partially addressed
Improve Counseling for Physical Activity (Ages 3–11 years)	Partially addressed
Improve Counseling for Physical Activity (Ages 12–17 years)	Partially addressed
Improve Counseling for Physical Activity (Total)	Partially addressed
Improve Follow-Up After Emergency Department Visit for Mental Illness (Ages 18 to 64 years, follow-up within 7 days)	Partially addressed
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Remains an opportunity for improvement

Recommendation for UPMC	IPRO Assessment of MCO Response[1]
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Remains an opportunity for improvement
Improve Adult Annual Dental Visit Women with a Live Birth (Ages 36–59 years)	Addressed
Improve Oral Evaluation, Dental Services (Ages < 1–20 years)	Partially addressed
Improve Topical Fluoride for Children (Dental/Oral Health Services)	Remains an opportunity for improvement
Improve Topical Fluoride for Children (Dental Services)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Ages 16–20 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Ages 21–24 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Total)	Remains an opportunity for improvement
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 15–20 years)	Remains an opportunity for improvement
Improve Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 15–20 years)	Remains an opportunity for improvement
Improve Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	Partially addressed
Improve Postpartum Screening for Depression	Addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	Partially addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older) Admissions per 100,000 member months	Addressed
Improve Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 18–64 Years of Age)	Remains an opportunity for improvement
Improve Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Total)	Remains an opportunity for improvement

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
CHIPRA: Children's Health Insurance Plan Reauthorization Act; EQR: external quality review; LARC: long-acting reversible contraceptive; MCO: managed care organization.

CHIP Response to Previous EQR Recommendations

Tables 85–91 display the CHIP-MCO responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

Note that due to HHK's MY 2022 merger of the former Highmark HMO, Highmark PPO, and NEPA, comparative MY 2022 data are not available to make determinations regarding whether these MY 2021 opportunities were addressed.

Table 85: CHIP-MCO – ABH Response to Previous EQR Recommendations

Recommendation for ABH	IPRO Assessment of MCO Response[1]
Improve Contraceptive Care for All Women (Ages 15–20 years): Most or Moderately Effective	Remains an opportunity for improvement
Improve Child and Adolescent Well-Care Visits (Ages 12−17 years)	Remains an opportunity for improvement

Recommendation for ABH	IPRO Assessment of MCO Response[1]
Improve Child and Adolescent Well-Care Visits (Ages 18–19 years)	Remains an opportunity for improvement
Improve Child and Adolescent Well-Care Visits (Total)	Remains an opportunity for improvement
Improve Follow-Up After Hospitalization For Mental Illness – 30 days	Addressed
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Remains an opportunity for improvement
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Remains an opportunity for improvement
Improve Asthma Medication Ratio (12–18 years)	Remains an opportunity for improvement
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1 year	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 1–9 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 10–19 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1–19 years Total Rate	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review; MM: member months.

Table 86: CHIP-MCO – CBC Response to Previous EQR Recommendations

Recommendation for CBC	IPRO Assessment of MCO Response[1]
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition (Ages 3–11 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity (Ages 3–11 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity (Total)	Addressed
Improve Immunizations for Adolescents – HPV	Remains an opportunity for improvement
Improve Immunizations for Adolescents – Combination 2	Remains an opportunity for improvement
Improve Lead Screening in Children (Age 2 years)	Addressed
Improve Chlamydia Screening in Women (Ages 16–20 years)	Remains an opportunity for improvement
Improve Developmental Screening in the First Three Years of Life – Total	Partially addressed
Improve Developmental Screening in the First Three Years of Life – 1 year	Partially addressed
Improve Developmental Screening in the First Three Years of Life – 2 years	Partially addressed
Improve Developmental Screening in the First Three Years of Life – 3 years	Partially addressed
Improve Annual Dental Visit (Ages 2–3 years)	Remains an opportunity for improvement
Improve Annual Dental Visit (Ages 4–6 years)	Remains an opportunity for improvement
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1 year	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 1–9 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 10–19 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1–19 years Total Rate	Partially addressed

Recommendation for CBC	IPRO Assessment of MCO Response[1]
Improve Ambulatory Care: Emergency Department Visits/1,000 MM Ages < 1 year	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review; MM: member months; HPV: human papillomavirus.

Table 87: CHIP-MCO – GEI Response to Previous EQR Recommendations

Recommendation for GEI	IPRO Assessment of MCO Response[1]
Improve Childhood Immunization Status − IPV	Addressed
Improve Childhood Immunization Status − VZV	Addressed
Improve Well-Child Visits in the First 30 Months of Life (Ages 15−30 months ≥ 2 Visits)	Addressed
Improve Child and Adolescent Well-Care Visits (Ages 12−17 years)	Addressed
Improve Lead Screening in Children (Ages 2 years)	Addressed
Improve Developmental Screening in the First Three Years of Life − Total	Partially addressed
Improve Developmental Screening in the First Three Years of Life − 1 year	Partially addressed
Improve Developmental Screening in the First Three Years of Life − 2 years	Addressed
Improve Developmental Screening in the First Three Years of Life − 3 years	Partially addressed
Improve Annual Dental Visit (Ages 4–6 years)	Addressed
Improve Appropriate Testing for Pharyngitis (Ages 3–17 years)	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1 year	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review; MM: member months; IPV: polio; VZV: chickenpox.

Table 88: CHIP-MCO – HPP Response to Previous EQR Recommendations

Recommendation for HPP	IPRO Assessment of MCO Response[1]
Improve Contraceptive Care for All Women (Ages 15–20 years): Most or Moderately Effective	Remains an opportunity for improvement
Improve Childhood Immunization Status—DTaP	Remains an opportunity for improvement
Improve Childhood Immunization Status—Pneumococcal Conjugate	Addressed
Improve Childhood Immunization Status—Rotavirus	Addressed
Improve Childhood Immunization Status—Combination 3	Addressed
Improve Childhood Immunization Status—Combination 7	Addressed
Improve Well-Child Visits in the First 30 Months of Life (Ages 15 months ≥ 6 Visits)	Remains an opportunity for improvement
Improve Well-Child Visits in the First 30 Months of Life (Ages 15–30 months ≥ 2 Visits)	Remains an opportunity for improvement
Improve Child and Adolescent Well-Care Visits (Ages 3−11 years)	Remains an opportunity for improvement
Improve Child and Adolescent Well-Care Visits (Ages 18−19 years)	Addressed
Improve Child and Adolescent Well-Care Visits (Total)	Remains an opportunity for improvement
Improve Appropriate Testing for Children with Pharyngitis (Ages 3–17 years)	Addressed
Improve Appropriate Testing for Children with Pharyngitis (Total)	Addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1 year	Partially addressed

Recommendation for HPP	IPRO Assessment of MCO Response[1]
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 1–9 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 10–19 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1–19 years Total Rate	Partially addressed
Improve Ambulatory Care: Emergency Department Visits/1,000 MM Ages < 1 year	Addressed
Improve Ambulatory Care: Emergency Department Visits/1,000 MM Ages 10–19 years	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined. MCO: managed care organization; EQR: external quality review; MM: member months; DTaP: diphtheria, tetanus and acellular pertussis.

Table 89: CHIP-MCO – IBC Response to Previous EQR Recommendations

Recommendation for IBC	IPRO Assessment of MCO Response[1]
Improve Contraceptive Care for All Women (Ages 15–20 years): Most or Moderately Effective	Remains an opportunity for improvement
Improve Lead Screening in Children (Ages 2 years)	Remains an opportunity for improvement
Improve Follow-Up Care for Children Prescribed ADHD Medication − Initiation Phase	Addressed
Improve Follow-Up After Hospitalization For Mental Illness − 30 days	Addressed
Improve Asthma Medication Ratio (Ages 5–11 years)	Addressed
Improve Asthma Medication Ratio (Total)	Addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1 year	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 1–9 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages 10–19 years	Partially addressed
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1–19 years Total Rate	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review; MM: member months; ADHD: attention deficit hyperactivity disorder

Table 90: CHIP-MCO – UHC Response to Previous EQR Recommendations

Recommendation for UHC	IPRO Assessment of MCO Response[1]
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Addressed
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Addressed
Improve Asthma Medication Ratio (Ages 12–18 years)	Partially addressed
Improve Asthma Medication Ratio (Total)	Remains an opportunity for improvement
Improve Ambulatory Care: Outpatient Visits/1,000 MM Ages < 1 year	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review; MM: member months.

Table 91: CHIP-MCO – UPMC Response to Previous EQR Recommendations

Recommendation for UPMC	IPRO Assessment of MCO Response[1]
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (Total)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 3–11 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 12–17 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Total)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Ages 12–17 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total)	Addressed
Improve Annual Dental Visit (Ages 2–3 years)	Addressed
Improve Annual Dental Visit (Ages 11–14 years)	Addressed
Improve Annual Dental Visit (Ages 15–18 years)	Addressed
Improve Annual Dental Visit (Total)	Addressed
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Remains an opportunity for improvement
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Remains an opportunity for improvement

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following 1) improvement was observed, but identified as an opportunity for current year; or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review; BMI: body mass index.

BH Response to Previous EQR Recommendations

In response to the opportunities for improvement identified in the 2022 (MY 2021) EQR Technical Report related to compliance with MMC regulations, BH-MCOs were required to submit descriptions of current and proposed interventions that address noted compliance deficiencies using an Opportunities for Improvement form developed by IPRO to ensure that responses were reported consistently across the PA MCOs. Generally, the activities followed a longitudinal format and were designed to capture information related to:

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

BH-MCOs were also required to prepare an RCA and QIP for underperformance of select QAPI performance measures as noted in the MY 2022 Goal Report. For 2022, BH-MCOs were required to address any FUH All-Ages rates that fell below the HEDIS MY 2022 quality Compass 75th percentile and any REA rates that were over the statewide threshold of 11.75%. These responses also had to address any (statistically significant) ethnic or racial disparities in rates. These MCOs were required to submit the following for each underperforming measure:

- A goal statement,
- Root cause analysis and analysis findings,

- Action plan to address findings,
- Implementation dates, and
- A monitoring plan to ensure action is effective and to address what will be measured and how often that measurement will occur.

Individual current and proposed interventions and applicable RCA and QIP for each 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 to inform the BH-MCO 2022 annual technical reports. **Tables 92–96** display IPRO's assessment of each BH-MCO's response.

Table 92: BH-MCO – Carelon Response to Opportunities for Improvement

Recommendation for Carelon	IPRO Assessment of MCO Response[1]
MY 2021 Compliance with Medicaid and CHIP Managed Care Regulations	
Within CMS EQR Protocol 3: Compliance with Standards, including Enrollee Rights and Protections, Carelon was partially compliant with five out of nine categories. Carelon was directed to submit an update on implemented and planned remediation activities to address: 1) Assurances of Adequate Capacity 2) Availability of Services 3) Coordination and continuity of care 4) Coverage and authorization of services 5) Practice guidelines 6) Quality Assessment and Performance Improvement Program 7) Grievance and appeal systems	Partially addressed
MY 2022 Performance Measures	
Improve HEDIS FUH 7-day (all ages)	Partially addressed
Improve HEDIS FUH 30-day (all ages)	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCO's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care plan; EQR: external quality review

Table 93: BH-MCO – CBH Response to Opportunities for Improvement

Recommendation for CBH	IPRO Assessment of MCO Response[1]
MY 2021 Compliance with Medicaid and CHIP Managed Care Regulations	
Within CMS EQR Protocol 3: Compliance with Standards, including Enrollee Rights and Protections, CBH was partially compliant with five out of nine categories. CBH was directed to submit an update on implemented and planned remediation activities to address: 1) Availability of Services 2) Coordination and continuity of care 3) Coverage and authorization of services 4) Practice guidelines 5) Provider selection 6) Grievance and appeal systems	Partially addressed
MY 2022 Performance Measures	
Improve HEDIS FUH 7-day (all ages)	Partially addressed
Improve HEDIS FUH 30-day (all ages)	Partially addressed
Improve REA	Remains an opportunity for improvement

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCO's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care plan; EQR: external quality review

Table 94: BH-MCO – CCBH Response to Opportunities for Improvement

Recommendation for CCBH	IPRO Assessment of MCO Response[1]
MY 2021 Compliance with Medicaid and CHIP Managed Care Regulations	
Within CMS EQR Protocol 3: Compliance with Standards, including Enrollee Rights and Protections, CCBH was partially compliant with four out of nine categories. CCBH was directed to submit an update on implemented and planned remediation activities to address: 1) Availability of Services 2) Coordination and continuity of care 3) Coverage and authorization of services 4) Practice guidelines 5) Grievance and appeal systems	Partially addressed
MY 2022 Performance Measures	
Improve HEDIS FUH 7-day (all ages)	Partially addressed
Improve HEDIS FUH 30-day (all ages)	Partially addressed
Improve REA	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCO's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care plan; EQR: external quality review

Table 95: BH-MCO – MBH Response to Opportunities for Improvement

Recommendation for MBH	IPRO Assessment of MCO Response[1]
MY 2021 Compliance with Medicaid and CHIP Managed Care Regulations	
MBH was directed to submit an update on implemented and planned remediation activities to address: 1) Coverage and authorization of services 2) Grievance and appeal systems	Addressed
MY 2022 Performance Measures	
Improve HEDIS FUH 7-day (all ages)	Addressed
Improve HEDIS FUH 30-day (all ages)	Partially addressed
Improve REA	Addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCO's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care plan; EQR: external quality review

Table 96: BH-MCO – PerformCare Response to Opportunities for Improvement

Recommendation for PerformCare	IPRO Assessment of MCO Response[1]
MY 2021 Compliance with Medicaid and CHIP Managed Care Regulations	
PerformCare was directed to submit an update on implemented and planned remediation activities to address: 1) Availability of Services 2) Coordination and continuity of care 3) Coverage and authorization of services 4) Practice guidelines 5) Grievance and appeal systems	Partially addressed
MY 2022 Performance Measures	
Improve HEDIS FUH 7-day (all ages)	Partially addressed
Improve HEDIS FUH 30-day (all ages)	Partially addressed
Improve REA	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCO's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review

CHC Response to Previous EQR Recommendations

Tables 97–100 display the CHC-MCOs' progress related to the *2022 External Quality Review Report,* as well as IPRO's assessment of CHC-MCOs' responses.

Table 97: CHC-MCO – ACP Response to Previous EQR Recommendations

Recommendation for ACP	IPRO Assessment of MCO Response[1]
Performance Improvement Projects	
It was recommended that the MCO improve its capacity to submit PIP reports in accordance with the submission schedule.	Addressed. The MCO submitted reports in accordance with the submission schedule, no further action is required.
Performance Measures and CAHPS Survey	
It was recommended that the MCO work on improving their rates for several HEDIS performance measures in the Effectiveness of Care domain.	Partially addressed.
It was recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Remains an opportunity for improvement. Rates for AADV continue to remain low and depict a continued opportunity for improvement.
Compliance with Medicaid and CHIP Managed Care Regulations	
There were no recommendations related to compliance with CFR Categories for Subparts D and E for the MCO for the measurement year	N/A – Not Applicable.

Table 98: CHC-MCO – KF Response to Previous EQR Recommendations

Recommendation for KF	IPRO Assessment of MCO Response[1]
Performance Improvement Projects	
It is recommended that the MCO improve its capacity to submit PIP reports in accordance with the submission schedule.	Addressed. The MCO submitted reports in accordance with the submission schedule, no further action is required.
Performance Measures and CAHPS Survey	
It is recommended that the MCO work on improving their rates for several HEDIS performance measures in the Effectiveness of Care Domain.	Partially addressed.
It is recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Remains an opportunity for improvement. Rates for AADV continue to remain low and depict a continued opportunity for improvement.
Compliance with Medicaid and CHIP Managed Care Regulations	
There were no recommendations related to compliance with CFR Categories for Subparts D and E for the MCO for the measurement year.	N/A – Not Applicable.

Table 99: CHC-MCO – PHW Response to Previous EQR Recommendations

Recommendation for PHW	IPRO Assessment of MCO Response[1]
Performance Improvement Projects	
There were no recommendations for the review year	N/A – Not Applicable.
Performance Measures and CAHPS Survey	
It was recommended that the MCO work on improving their rates for several HEDIS performance measures in the Effectiveness of Care and Access/Availability of Care domains.	Remains an opportunity for improvement.
It was recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Remains an opportunity for improvement. Rates for AADV continue to remain low and depict a continued opportunity for improvement.
Compliance with Medicaid and CHIP Managed Care Regulations	
There were no recommendations related to compliance with CFR Categories for Subparts D and E.	N/A – Not Applicable.

Table 100: CHC-MCO – UPMC Response to Previous EQR Recommendations

Recommendation for UPMC	IPRO Assessment of MCO Response[1]
Performance Improvement Projects	
It was recommended that the MCO improve data reporting capabilities to ensure accurate data is reported for PIP validation in accordance with the submission schedule.	Addressed. The MCO demonstrated improvement in their data reporting for the PIPs.
Performance Measures and CAHPS Survey	
It was recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Remains an opportunity for improvement. Rates for AADV continue to remain low and depict a continued opportunity for improvement.
Compliance with Medicaid and CHIP Managed Care Regulations	
There were no recommendations related to compliance with CFR Categories for Subparts D and E for the MCO for the measurement year.	N/A – Not Applicable.

[1] The EQRO assessments are as follows: **addressed:** MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either 1) improvement was observed but identified as an opportunity for current year or 2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed, or performance declined.
ACP: AmeriHealth Caritas Pennsylvania; KF: Keystone First; PHW: Pennsylvania Health and Wellness; UPMC: University of Pittsburgh Medical Center; CHC: Community HealthChoices; EQR: external quality review; EQRO: external quality review organization; MCO: managed care organization.

IX. EQR Recommendations

Tables 101–104 highlight this year's recommendations based on the aggregated results of MY 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**. Individual MCO reports provide detailed information on each plan's strengths and opportunities. A checkmark indicates the recommendation falls under the quality, timeliness, or access domain.

PH-MCO EQR Recommendations

Table 101: PH-MCO EQR Recommendations

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
PH-MCO - ACP				
PIP: Preventing Inappropriate Use or Overuse of Opioids	Future PIP submissions should focus on addressing data consistency, merger effects, detailed analysis of interventions, and sustained improvement strategies.	✓	-	-
PIP: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Future PIP submissions should set bold performance indicator goals, focus on addressing African American member outreach, merger effects, a detailed barrier analysis, and intervention modifications.	✓	-	✓
Performance Measures	It is recommended that ACP work to improve access to and availability of care for both dental services and ambulatory health services.	✓	-	✓
Performance Measures	It is recommended that ACP work to improve access to and availability of care for the initiation of alcohol use disorder for ages 13 to 17 years.	✓	✓	✓
Performance Measures	It is recommended that ACP work to improve behavioral health care and depression screenings.	✓	✓	✓
Performance Measures	It is recommended that ACP work to improve dental and oral health services, particularly regarding oral evaluation and sealant receipt for members 1 and 2 years old.	✓	-	✓
Performance Measures	It is recommended that ACP work to improve prenatal depression screenings and follow up. This measure is an ECDS measure.	✓	✓	✓
Performance Measures	It is recommended that ACP work to improve maternal and perinatal health care, focusing on prenatal counseling for environmental tobacco smoke exposure (ETS).	✓	✓	✓
Performance Measures	It is recommended that ACP work to improve in areas of overuse or appropriateness by focusing on population use of concurrent opioids and benzodiazepines and overuse of antibiotics for acute bronchitis.	✓	-	-
Performance Measures	It is recommended that ACP work to improve in areas of prevention and screening. Timely developmental screenings for 1-, 2- and 3-year-olds, chlamydia screenings for 16 to 24 year olds, influenza immunizations for children, and weight and physical activity counseling for 12 to	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	17 year olds are all areas the MCO should focus on.			
Performance Measures	It is recommended that ACP work to improve testing for respiratory conditions, particularly ensuring appropriate testing for pharyngitis.	✓	-	✓
Performance Measures	It is recommended that ACP work to improve ambulatory care emergency department and outpatient utilization, as well as antibiotic utilization for respiratory conditions, for its older population, 65 years and older.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	It is recommended that ACP work to address their partial compliance for the Health Information Systems category under the MCO, PIHP, and PAHP Standards Regulations heading.	-	-	✓
Quality of Care Surveys	It is recommended that ACP improve adult member satisfaction with a focus on getting needed information, satisfaction with healthcare, and appointment for routine care when needed. Additionally, ACP should focus on satisfaction with the child's health plan for members 17 years old and younger.	✓	✓	✓
PH-MCO - GEI				
PIP: Preventing Inappropriate Use or Overuse of Opioids	Future PIP submissions should focus on articulating an aim statement and objectives that align with each performance indicator, addressing recurrent, detailed barrier analysis, and modification of low-performing interventions. The barrier analysis should include examining race and ethnicity barriers.	✓	-	✓
PIP: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Future PIP submissions should focus on articulating an aim statement and objectives that align with each performance indicator, addressing recurrent, detailed barrier analysis, and modification of low-performing interventions. GEI should interpret performance indicator rates using ITM data, providing insights into the degree of goal achievement and address factors associated with success or failure, including ITM rates, documented findings from barrier analysis, and modifications to interventions. Future submissions should consider internal and external threats to validity.	✓	-	-
Performance Measures	It is recommended that GEI work to improve access to and availability of care for both dental visits and preventive ambulatory health services for adults 65 years and older.	✓	-	✓
Performance Measures	It is recommended that GEI work to improve behavioral health care in the following areas: adherence to antipsychotic medications for members with schizophrenia, depression screenings, and follow-up care for children prescribed ADHD medication.	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures	It is recommended that GEI work to improve dental and oral health services, particularly topical fluoride for children ages 1 to 2 years old.	✓	✓	✓
Performance Measures	It is recommended that GEI work to improve care surrounding diabetes, focusing on members that received statin therapy as part of their diabetes treatment.	✓	-	✓
Performance Measures	It is recommended that GEI work to improve maternal and perinatal health care in the following areas: (1) focusing on accessibility of LARC within 90 days of delivery for postpartum women, (2) prenatal screening for environmental tobacco smoke exposure (ETS), and (3) prenatal smoking cessation.	✓	✓	✓
Performance Measures	It is recommended that GEI work to improve in areas of overuse or appropriateness by focusing on avoidance of antibiotic treatment for members diagnosed with acute bronchitis or bronchiolitis.	✓	✓	-
Performance Measures	It is recommended that GEI focuses improvement on prevention and screening in the following areas: (1) development screenings in the first three years of a member's life, (2) chlamydia screenings for member age 16 to 24 years old, and (3) adolescent immunizations for HPV and Combination 2.	✓	✓	✓
Performance Measures	It is recommended that GEI work to improve care for respiratory conditions for both appropriate testing for pharyngitis and asthma medications.	✓	-	-
Performance Measures	It is recommended that GEI work to improve ambulatory care emergency department and outpatient utilization, as well as working to reduce admissions due to short-term complications related to diabetes.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	Given that the MCO was found to be compliant on all SMART Items across Subparts C, D, E, and F, there are no recommendations for the MCO for MY 2022.	✓	✓	✓
Quality of Care Surveys	GEI should focus on improving adult member satisfaction in getting needed information and satisfaction with health care. For members age 17 years and younger, GEI should focus on satisfaction with the child's health plan, information or help from customer service, and satisfaction with health care.	✓	-	✓
PH-MCO - HWC				
PIPs: Preventing Inappropriate Use or Overuse of Opioids	Future PIP submissions should include recurrent, detailed barrier analysis from a variety of quality improvement processes, including direct member/provider feedback, and modification of any low-performing interventions. Additionally, HWC should identify	✓	-	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	barriers related to susceptible subpopulations and address health disparities in these groups.			
PIPs: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Future PIP submissions should include the incorporation of recurrent, detailed barrier analysis from a variety of quality improvement processes, and the modification of any underperforming interventions, demonstrating a proactive approach to ongoing improvement initiatives.	✓	-	-
Performance Measures	It is recommended that HWC work to improve access to and availability of care, focusing on annual dental visits for members 65 years and older and access to preventive ambulatory health services.	✓	-	✓
Performance Measures	It is recommended that HWC work to improve behavioral health care with a focus on members with poor HBA1C control for people with diabetes and serious mental illness, and antidepressant medication management.	✓	✓	✓
Performance Measures	It is recommended that HWC work to improve care related to cardiovascular conditions, particularly cardiac rehabilitation and statin therapy for members.	✓	✓	✓
Performance Measures	It is recommended that HWC focus on areas of care for dental and oral health services, particularly oral evaluation for members 1 to 18 years old and topical fluoride for its members.	✓	-	✓
Performance Measures	It is recommended that HWC work to improve kidney health evaluation for its members with diabetes.	✓	-	✓
Performance Measures	It is recommended that HWC work to improve prenatal and postpartum depression screening and follow-ups.	✓	✓	✓
Performance Measures	It is recommended that HWC work to improve maternal and perinatal health in its members by focusing on accessibility of contraceptives for postpartum members and smoking and depression screenings for its prenatal and postpartum members.	✓	✓	✓
Performance Measures	It is recommended that HWC work to improve in the area of overuse and appropriateness by focusing on use of imaging studies for low back pain.	✓	-	✓
Performance Measures	It is recommended that HWC work to improve prevention and screening, particularly breast cancer and chlamydia screenings for its members.	✓	-	✓
Performance Measures	It is recommended that HWC work to improve ambulatory care emergency department and outpatient utilization, antibiotic utilization for respiratory conditions, COPD and heart failure admissions, as well as admissions from short-term complications for members with diabetes.	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Compliance with Medicaid and CHIP Managed Care Regulations	It is recommended that HWC work to address their partial compliance for the health information services category.	-	-	✓
Quality of Care Surveys	It is recommended that HWC improves adult member satisfaction with a focus on satisfaction with the adult's health plan and health care. Additionally, HWC should focus on satisfaction with the health care for members 17 years old and younger.	✓	✓	✓
PH-MCO - HPP				
PIP: Preventing Inappropriate Use or Overuse of Opioids	Future PIP submissions should focus on a recurrent, detailed barrier analysis and modification of low-performing interventions were recommended in future PIP submissions	✓	-	-
PIP: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Future PIP submissions should include a historical narrative of previously retired interventions in the Aims and Objectives section for a comprehensive view of interventions during the PIP's lifecycle in future submissions.	✓	-	-
Performance Measures	It is recommended that HPP work to improve access to and availability of care in the following areas: (1) annual dental visits for members both with and without developmental disabilities, (2) substance use disorder (SUD) treatment for alcohol and other drugs, and (3) preventive ambulatory health services.	✓	-	✓
Performance Measures	It is recommended that HPP work to improve behavioral health care in the following areas: (1) medication management for members with schizophrenia or depression, (2) 30 day follow-up after emergency visits for mental illness, (3) depression screenings, and (4) metabolic monitoring for children and adolescents on antipsychotics.	✓	✓	✓
Performance Measures	It is recommended that HPP work to improve care related to cardiovascular conditions, focusing on high blood pressure, beta-blocker treatment after heart attack, and statin therapy for members with cardiovascular disease.	✓	✓	-
Performance Measures	It is recommended that HPP work to improve dental and oral health services related to topical fluoride for members ages 1 to 2 years old.	✓	-	✓
Performance Measures	It is recommended that HPP work to improve care related to blood pressure control, eye exams, and statin therapy for members with diabetes.	✓	-	✓
Performance Measures	It is recommended that HPP focus on the following areas of care: (1) adult immunizations for influenza, Td/TDaP, and Zoster, (2) positive depression screening follow-up for adolescents, adults, and postpartum members.	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures	It is recommended that HPP work to improve maternal and perinatal health with focus on ensuring members age 15 to 20 years old have access to most or moderately effective contraception, as well as smoking and depression screenings for members that are prenatal and postpartum.	✓	✓	✓
Performance Measures	It is recommended that HPP focuses improvement on prevention and screening in the following areas: (1) developmental screenings for members age 1 to 3 years old, (2) colorectal cancer screenings for members age 50 years and older, and (3) lead screenings for children.	✓	✓	✓
Performance Measures	It is recommended that HPP work to improve care for respiratory conditions regarding testing for pharyngitis, as well as pharmacotherapy management and spirometry testing for member with Chronic Obstructive Pulmonary Disease (COPD).	✓	-	-
Performance Measures	It is recommended that HPP work to improve ambulatory care emergency department and outpatient utilization, as well as asthma admissions for members age 2 to 29 years, antibiotic utilization for respiratory conditions, and well-child visits in the first 30 months of life.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	It is recommended that HPP work to address their partial compliance for the Health Information Systems category under the MCO, PIHP, and PAHP Standards Regulations category.	-	-	✓
Quality of Care Surveys	It is recommended that HPP improve adult member satisfaction with a focus on satisfaction with the adult's health plan and obtaining an appointment when needed for routine care.	✓	✓	✓
PH-MCO - KF				
PIPs: Preventing Inappropriate Use or Overuse of Opioids	Recommendations include the need for more detailed initial and ongoing barrier analyses and early intervention modification in subsequent PIP cycles, ensuring a timely review of trends.	✓	✓	✓
PIPs: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Recommendations include the need for more robust initial and ongoing barrier analyses that engaged providers. Based on the analyses, interventions should clearly align with the PIP aim, objectives, and performance indicators.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve access to and availability of care for adult dental visits, initiation and engagement of substance use disorder, psychosocial care for children and adolescents on antipsychotics, and preventive ambulatory health services.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve behavioral health care with a focus on the	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	following areas: (1) medication adherence for members with schizophrenia, (2) follow-up after emergency department visit for member with mental illness, (3) pharmacotherapy for members with opioid use disorder, (4) depression screening and follow-up, (5) follow-up for children prescribed ADHD medication, and (6) metabolic monitoring for children on antipsychotics.			
Performance Measures	It is recommended that KF work to improve dental and oral health services, particularly regarding sealant receipt on permanent first molars for its members.	✓	-	✓
Performance Measures	It is recommended that KF work to improve blood pressure control, eye exam availability, and hemoglobin A1c control for patients with diabetes.	✓	✓	✓
Performance Measures	It is recommended that KF focus on improvement on the following areas: (1) adult immunizations for Td/TDaP, (2) colorectal cancer screening, (3) follow-up for children prescribed ADHD medication, (4) metabolic monitoring for children on antipsychotics, and (5) follow-ups on positive depression screenings for postpartum members.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve maternal and perinatal health by focusing on access to contraceptive care for its members and smoking and depression screenings for its prenatal and postpartum members.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve in the area of overuse and appropriateness by focusing on appropriate treatment for members with upper respiratory infection and member use of opioids at high dosage.	✓	-	-
Performance Measures	It is recommended that KF work to improve prevention and screening, particularly regarding colorectal cancer screenings for its members.	✓	-	✓
Performance Measures	It is recommended that KF work to improve care related to respiratory conditions with a focus on appropriate pharyngitis testing and asthma medication prescription.	✓	-	
Performance Measures	It is recommended that KF focus on improvement regarding asthma related admissions for younger adults, COPD admissions in older adults, short-term admissions related to complications with diabetes, heart failure admissions, and emergency department and outpatient visit utilization for ambulatory care.	✓	-	✓
Compliance with Medicaid and CHIP Managed Care Regulations	It is recommended that KF work to address their partial compliance for the health information services category.	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Quality of Care Surveys	It is recommended that KF improve child member satisfaction with a focus on information or help from customer service, satisfaction with healthcare, and obtaining an appointment for routine care when needed. Additionally, KF should focus on adult member satisfaction on the adult's health plan.	✓	✓	✓
PH-MCO - UHC				
PIPs: Preventing Inappropriate Use or Overuse of Opioids	It is recommended that UHC make modifications for successful member outreach and engagement, particularly for low-performing ITMs (ITM 1, 5, 6, 7), considering the impact of the pandemic on resources and capacity.	✓	✓	✓
PIPs: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	It was recommended that the MCO investigate why some of the ITMs were low considering telephonic outreach.	✓	✓	✓
Performance Measures	UHC should improve access to/availability of care with a focus on adult annual dental visits, adults' access to preventative/ambulatory health services, and initiation and engagement of substance use disorders.	-	✓	✓
Performance Measures	UHC should improve measures for behavioral healthcare with a focus on adherence to antipsychotic medications for individuals with schizophrenia, follow-up after an ED visit for mental illness, screening for depression and follow-up, antidepressant medication management, follow-up care for children prescribed ADHA medication, and pharmacotherapy for opioid use disorder.	✓	✓	-
Performance Measures	UHC should improve performance on measures for cardiovascular conditions with a focus on controlling high blood pressure and statin therapy for patients with cardiovascular disease.	✓	-	-
Performance Measures	UHC should improve oral evaluation-dental services for children.	✓	-	✓
Performance Measures	UHC should improve eye exams and statin therapy for patients with diabetes.	✓	-	-
Performance Measures	UHC should improve ECDS measures with a focus on depression screening and follow-up for adolescents and adults, prenatal and postpartum depression screening, and prenatal immunizations.	✓	✓	-
Performance Measures	UHC should improve maternal and perinatal health measures related to contraceptive care and perinatal depression screening.	✓	✓	-
Performance Measures	UHC should improve prevention and screening for breast cancer, colorectal cancer, and immunizations for adolescents.	✓	✓	-

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures	UHC should improve care for respiratory conditions with a focus on asthma medication ratio and pharmacotherapy management for COPD.	✓	✓	-
Performance Measures	UHC should focus on hospital and ambulatory care utilization for asthma in younger adults, COPD or asthma in older adults, diabetes short-term complications, ED visits, and outpatient visits. UHC should work to improve antibiotic utilization for respiratory conditions and well-child visits in the first 30 months of life.	-	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	It is recommended that UHC work to address their partial compliance for the health information services category.	✓	✓	✓
Quality of Care Surveys	It is recommended that UHC improves child member satisfaction with a focus on satisfaction with the child's health plan, information or help from customer service, and obtaining an appointment for routine care when needed. Additionally, UHC should focus on adult member satisfaction on the adult's health plan and obtaining an appointment for routine care when needed.	✓	✓	✓
PH-MCO - UPMC				
PIPs: Preventing Inappropriate Use or Overuse of Opioids	It is recommended that the MCO include targeted interventions to the identified susceptible subpopulation in the next PIP cycle.	✓	-	✓
PIPs: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	It is recommended that the MCO include targeted interventions to the identified susceptible subpopulation in the next PIP cycle and evaluate the study's threats to internal and external validity.	✓	✓	✓
Performance Measures	It is recommended that UPMC improve access to/availability of care for annual dental visits, annual dental visits for members with developmental disabilities, and initiation and engagement of substance use disorder.	✓	✓	✓
Performance Measures	It is recommended that UPMC improve behavioral health care for diabetes care for people with serious mental illness.	✓	✓	✓
Performance Measures	It is recommended that UPMC improve dental and oral health services for oral evaluations, sealants on permanent first year molars, and topical fluoride for children.	✓	✓	✓
Performance Measures	It is recommended that UPMC improve maternal and perinatal health, focusing on contractive care for postpartum women and prenatal depression screening.	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures	It is recommended that UPMC improve overuse/appropriateness of antibiotic treatment of acute bronchitis/bronchiolitis.	✓	-	-
Performance Measures	It is recommended the UPMC improve prevention and screening for chlamydia in women and childhood immunizations.	✓	✓	✓
Performance Measures	It is recommended that UPMC improve healthcare utilization, focusing on emergency department visits for children ages less than 1 to 9 years.	-	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	Given that the MCO was found to be compliant on all SMART Items across Subparts C, D, E, and F, there are no recommendations for the MCO for MY 2022.	-	-	-
Quality of Care Surveys	It is recommended that UPMC improve child member satisfaction with a focus on satisfaction with the child's health plan.	✓	✓	✓

MCO: managed care plan; EQR: external quality review; PIP: performance improvement project; SFY: state fiscal year

Targeted opportunities for improvement were made for PH-MCOs regarding select measures via MCO-Specific Matrices and root cause analyses. The PH-MCO 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.

Figure 2 displays the P4P measures for each PH-MCO requiring a root cause analysis and action plan.

Rating	ACP	GEI	HPP	HWC	KF	UHC	UPMC
D	Developmental Screening in the First Three Years of Life	Asthma Medication Ratio Well–Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits)[1]	Controlling High Blood Pressure Lead Screening in Children Well-Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits) [1]	Child and Adolescent Well-Care Visits (Ages 3—21 years)	No measures fell into this category	Asthma Medication Ratio Child and Adolescent Well-Care Visits (Ages 3–21 years) Controlling High Blood Pressure	No measures fell into this category
F	Annual Dental Visit (Ages 2–20 years)[2] Child and Adolescent Well-Care Visits (Ages 3–21 years)	Developmental Screening in the First Three Years of Life	Child and Adolescent Well-Care Visits (Ages 3–21 years)	No measures fell into this category	Asthma Medication Ratio	Plan All-Cause Readmissions[3] Well–Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits)	No measures fell into this category

Figure 2: PH-MCO Root Cause Analysis for 2023 (MY 2022) Measure Results

[1] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaces Well-Child Visits in the First 15 Months of Life, 6 or more.

[2] Annual Dental Visit (Ages 2 – 20 years) was added as a P4P measure in 2022 (MY 2021).

[3] Plan All Cause Readmissions was added as a P4P measure in 2022 (MY 2021). Lower rates indicate better performance.

CHIP-MCO EQR Recommendations

Table 102: CHIP-MCO EQR Recommendations

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
CHIP-MCO - ABH				
PIP: Improving Access to Pediatric Preventive Dental Care	The MCO's final report should include a focus on robust barrier analysis for Indicator 8.	✓	-	-
PIP: Improving Blood Lead Screening Rate in Children	The MCO's final report should provide an in-depth look at the reliability of the EPSDT/Bright Futures Compliance Report in their project, as well as rationale for the interpretation of Indicator 2 performance.	✓	-	-
Performance Measures	It is recommended that ABH work to improve behavioral health care regarding follow-up after emergency department visits for mental illness.	✓	✓	-
Performance Measures	It is recommended that ABH work to improve dental and oral health services, particularly focusing on dental sealant receipt for eligible members.	✓	-	✓
Performance Measures	It is recommended that ABH work to improve maternal and perinatal health care with a focus on contraceptive care accessibility for its members.	✓	-	✓
Performance Measures	It is recommended that ABH work to improve utilization, particularly focusing on outpatient visits for ambulatory care and well-child visits for members ages 15−30 months.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality-of-Care Surveys	It is recommended that ABH improve health care, health plan, and personal doctor satisfaction within its membership. An additional focus should be improving access to mental and emotional health care for members.	✓	-	✓
CHIP-MCO - CBC				
PIP: Improving Access to Pediatric Preventive Dental Care	It is recommended that the MCO to perform another barrier analysis and subsequent development or modification of new interventions related to Indicator 2, "Total Eligible Members Receiving Preventive Dental Services."	✓	-	✓
PIP: Improving Blood Lead Screening Rate in Children	It is recommended that the MCO discuss how often the new intervention's work group will be reviewing intervention performance in the next PIP submission. CBC should also consider including an ITM that measures the total number of members who received blood lead screening after lead campaign email was sent to members.	✓	✓	-

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures	It is recommended that CBC work to improve access to and availability of care for dental services.	✓	-	✓
Performance Measures	It is recommended that CBC work to improve in areas of prevention and screening. Childhood immunizations and developmental screenings are areas that the MCO should focus on.	✓	✓	✓
Performance Measures	It is recommended that CBC work to improve ambulatory care emergency department and outpatient utilization.	✓	✓	-
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality-of-Care Surveys	It is recommended that CBC improve access and availability of mental health care for members.	✓	-	✓
CHIP-MCO - GEI				
PIP: Improving Access to Pediatric Preventive Dental Care	The MCO's final report should include additional details surrounding the interventions detailed in their interim report.	✓	-	-
PIP: Improving Blood Lead Screening Rate in Children	The MCO's final report should include comprehensive timelines for all indicators, revised barriers and/or interventions to cohesion of the aim of the project, and complete data for all ITMs for associated interventions.	✓	-	-
Performance Measures	It is recommended that GEI work to improve in areas of prevention and screening. Developmental screening, immunizations for adolescents, and weight assessment and counseling for nutrition and physical activity are all areas that the MCO should focus on.	✓	-	✓
Performance Measures	It is recommended that GEI work to improve testing for respiratory conditions, particularly ensuring appropriate testing for pharyngitis.	✓	-	✓
Performance Measures	It is recommended that GEI work to improve well-child and well-care visits, as well as ambulatory care emergency department and outpatient utilization.	✓	-	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality-of-Care Surveys	It is recommended that GEI work to improve satisfaction with health care and quality of mental health care for its members.	✓	✓	✓
CHIP-MCO - HPP				

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
PIP: Improving Access to Pediatric Preventive Dental Care	The MCO met all criteria for review as of their November 2023 Interim Report submission. There are no associated recommendations for this project.	✓	✓	✓
PIP: Improving Blood Lead Screening Rate in Children	Final PIP submissions should include a further development of subcategories for ITM 1, focusing on outreach efforts for this intervention.	-	-	✓
Performance Measures	It is recommended that HPP work to improve access to and availability of care for annual dental visits.	-	-	✓
Performance Measures	It is recommended that HPP work to improve behavioral health care with a focus on follow-up care for children prescribed ADHD medication in the initiation phase.	-	✓	✓
Performance Measures	It is recommended that HPP work to improve maternal and perinatal health care, focusing on access to contraceptive care.	-	-	✓
Performance Measures	It is recommended that HPP work to improve in areas of prevention and screening. Focus should be on childhood and adolescent immunizations, as well as weight assessment and counseling for nutrition and physical activity.	-	✓	✓
Performance Measures	It is recommended that HPP work to improve ambulatory care emergency department and outpatient utilization, as well as well-care visits for children and adolescents.	-	-	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality of Care Surveys	It is recommended that HPP improve health care, health plan, and specialist satisfaction within its membership. An additional focus should be improving access to mental and emotional health care for members.	✓	✓	✓
CHIP-MCO - HHK				
PIP: Improving Access to Pediatric Preventive Dental Care	No recommendations	-	-	-
PIP: Improving Blood Lead Screening Rate in Children	No recommendations	-	-	-
Performance Measures	It is recommended that HHK work to improve access to and availability of care, particularly focusing on annual dental visits.	✓	-	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures	It is recommended that HHK work to improve in areas of prevention and screening, particularly focusing on immunizations for adolescents and chlamydia screenings.	✓	✓	-
Performance Measures	It is recommended that HHK work to improve ambulatory care emergency department and outpatient utilization.	✓	-	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality-of-Care Surveys	It is recommended that HHK focus on improving member satisfaction with personal doctors and specialists.	✓	-	-
CHIP-MCO - IBC				
PIP: Improving Access to Pediatric Preventive Dental Care	No recommendations	-	-	-
PIP: Improving Blood Lead Screening Rate in Children	Revisions to IBC's Intervention 3 in the next PIP submission are recommended, focusing on inclusion of members residing in high-risk ZIP codes.	✓	-	✓
Performance Measures	It is recommended that IBC work to improve maternal and perinatal health care, focusing on access to contraceptive care for members ages 15–20 years.	✓	✓	✓
Performance Measures	It is recommended that IBC work to improve in areas of overuse or appropriateness by focusing on asthma-related emergency department visits for its members.	✓	✓	-
Performance Measures	It is recommended that IBC work to improve in lead screening for members 2 years of age.	✓	-	✓
Performance Measures	It is recommended that IBC work to improve ambulatory care emergency department and outpatient utilization.	✓	-	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality-of-Care Surveys	It is recommended that IBC improve satisfaction with health care, specialists, personal doctors, and health plan within its membership. An additional focus should be improving access to mental and emotional health care for members.	✓	✓	✓
CHIP-MCO - UHC				
PIP: Improving Access to Pediatric Preventive Dental Care	In future submissions, it was recommended that UHC consider additional barrier analyses and subsequent intervention modifications for Interventions 1 and 4.	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
PIP: Improving Blood Lead Screening Rate in Children	In the final report, it was recommended that UHC provide a more in-depth discussion in the Discussion section of the PIP regarding the rationale for why a lower rate is the desired performance outcome goal for Indicator 2.	✓	✓	✓
Performance Measures	It is recommended that UHC work to improve testing for respiratory conditions, particularly focusing on asthma medication.	✓	✓	-
Performance Measures	It is recommended that UHC work to improve ambulatory care emergency department and outpatient utilization, as well as well-child visits for members in their first 15 months of life.		✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality-of-Care Surveys	It is recommended that UHC improve personal doctor satisfaction and access to mental and emotional health care for members.	✓	-	-
CHIP-MCO - UPMC				
PIP: Improving Access to Pediatric Preventive Dental Care	It is recommended that UPMC include in their next submission details surrounding member education in Intervention 1, particularly focusing on whether sessions will be one-on-one or group, as well as the frequency of the sessions.	✓	-	✓
PIP: Improving Blood Lead Screening Rate in Children	It is recommended that UPMC consider including additional information in the Discussion section on the plan's overall evaluation of the degree to which the goals and objectives were met in relation to Indicator 2's interventions/ITMs and final goal rate.	✓	✓	✓
Performance Measures	It is recommended that UPMC work to improve dental and oral health services, particularly focusing on sealant receipt on permanent first molars.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	-	-	-
Quality-of-Care Surveys	It is recommended that UPMC focus on improving member satisfaction with personal doctors and specialists, as well as access to mental and emotional health care for members.	✓	✓	✓

EPSDT: early and periodic screening, diagnostic, and treatment; MCO: managed care organization; EQR: external quality review; PIP: performance improvement project; ITM: intervention tracking measure; ADHD: attention-deficit/hyperactivity disorder.

BH-MCO EQR Recommendations

Table 103: BH-MCO EQR Recommendations

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Carelon				
PIP: Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	As relates to Rating 1, IPRO recommends the following: 1) data collection, monitoring, and analysis plans (Methodology section) should be updated to reflect the new ITMs 2) a need to conduct a data-driven analysis (informed by a logic model of change) of the potential intervention-related causes of observed changes in performance indicators, starting with analysis of trends in the ITMs. As relates to Rating 2, IPRO recommends the following: 3) ITMs should be re-examined for measurement validity, as performance indicators improved despite downward trends for some ITMs. 4) If warranted (based on findings), the PIP's logic model of change should be reassessed and updated. This may entail a reassessment of the hypothesized effectiveness of the interventions.	✓	✓	✓
Performance Measures: HEDIS FUH 7- and 30-day (all ages)	IPRO concurs with Carelon's findings of its RCA and proposed remediations in its QIP, which center on addressing previously identified barriers while working with facilities to promote documentation of workflows, contacts, and other relevant shared knowledge related to discharge planning and follow-up. Carelon's excellent monitoring plan, including its comprehensive care coordination process measure, if successfully implemented, will continue to yield insights to inform ways to expand on some promising improvements and finally increase its overall FUH rates.	-	✓	✓
Performance Measures: PA FUH 7- and 30-day (all ages)	See HEDIS FUH	-	✓	✓
Performance Measures: REA	Carelon should examine what changes occurred in network composition, service delivery, data management, or other factors which may have contributed to its success so that it may build on the improvements made in MY 2022.	-	✓	✓
Compliance: Assurances of adequate	Carelon should work with Beaver and Fayette counties to ensure all reporting requirements are met.	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
capacity and services				
Compliance: Availability of Services	Prior recommendations for the triennial substandard deficiencies remain until next review. Carelon should work with Beaver and Fayette counties to ensure all reporting requirements are met.	✓	✓	✓
Compliance: Coordination and continuity of care	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Coverage and authorization of services	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Quality assessment and performance improvement program	IPRO concurs with OMHSAS's recommendation: The 2021 and 2022 QM Work Plans identified the same performance improvement areas based on the Program Evaluation Findings. Carelon should consider a meaningful analysis of these areas and whether there has been any progress in the past three years that may allow for a more specific or targeted goal. Progress toward integration of provider profiles and VBP performance metrics, successes or challenges in the PEDTAR PIP, identification of challenging areas in the satisfaction surveys, identified health disparities, changes in rates of MAT, and completed implementation of SRE policies may prompt the identification of more specific performance improvement areas.	✓	✓	✓
Compliance: Grievance and appeal systems	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	✓	✓	✓
CBH				
PIP: Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	As relates to Rating 1, IPRO recommends the following: 1) CBH should revisit its logic model of change to ensure the important points and links in its causal chains are being validly measured. In its logic mode of change, CBH should take into account duration as well as scope of interventions when considering likely impacts (and when those impacts should occur). Analysis should be carried out according to its data analysis plan, and discussion should be clearly written describing and then interpreting the findings according to its logic model of	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	change while at the same time describing any threats to internal and external validity which would aid the reader in assessing the confidence levels of those findings. Furthermore, if findings suggest it, the logic model of change itself should be revisited and updated if needed. A report that clearly lays out the above considerations will then serve as a document of learning which is after all a centerpiece of a PIP. As relates to Rating 2, IPRO recommends the following: 1) Spread and sustainability of improvements will depend on the extent to which the challenges noted above related to planning, execution, analysis, and learning are addressed. CBH should therefore ensure new interventions are of sufficient scope and duration to meaningfully address identified barriers while putting in place ITMs that reliably measure progress on addressing those barriers. 2) Standing up continuous monitoring of all levels of the system, including aggregations of providers like hospital systems, consistent with its logic model of change, will help inform midcourse corrections that are timely (not too reactive nor too lagged) and appropriate.			
Performance Measures: HEDIS FUH 7- and 30-day (all ages)	CBH's remarkable improvement in MY 2022 over previous years in FUH rates should spur CBH and its Primary Contractor, Philadelphia, to identify the changes in the network, care delivery, data management, and other factors which may have contributed to the increase in follow-up rates. CBH's root cause analyses for HEDIS FUH reported no racial or ethnic disparities in MY 2022 rates but did identify other disparities associated with age and gender. CBH also reports provider staff shortages and turnover as relevant barriers. IPRO largely agrees with CBH's proposed remediations in its HEDIS FUH quality improvement plans which center on expanding discharge planning training and supports through interventions such as Project RED and improving communication and coordination through provider participation in data exchanges and timely case management coordination while members are still inpatient. Other member-level barriers appear to be more entrenched and may require further drilldowns	-	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	by diagnostic and demographic stratifications to better identify leverage points for timely initiation and engagement in treatment.			
Performance Measures: PA FUH 7- and 30-day (all ages)	See HEDIS FUH. Given that FUH rates remain too low, CBH and Philadelphia should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to build on the improvement in MY 2022.	-	✓	✓
Performance Measures: REA	CBH and Philadelphia should examine their PEDTAR PIP data to see what interventions, if any, are particularly effective at reducing MH-related readmissions for this population.	-	✓	✓
Compliance: Availability of Services	IPRO concurs with OMHSAS's assessment that the SUD medical necessity template elicited more robust clinical information, although a review of the type of information needed for each dimension should be reviewed with the care manager. More generally, care managers should request more detailed information from providers with regular follow-up to ensure the requested information has been shared. To the extent that provider staff turnover exacerbates protocol breakdowns, CBH should work with its providers to document, and orient to, processes and procedures related to authorization and utilization management.	✓	✓	✓
Compliance: Coordination and continuity of care	See Availability of Services.	✓	✓	✓
Compliance: Coverage and authorization of services	See Availability of Services.	✓	✓	✓
Compliance: Practice Guidelines	See Availability of Services.	✓	✓	✓
Compliance: Quality Provider selection	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Grievance and appeal systems	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
CCBH				
PIP: Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	As relates to Rating 1, IPRO recommends the following: 1) The only note of caution is some of the low response rates of some of the public	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	health surveys, especially for the Anti-Stigma Campaign (ITM PHb.ii) in Q4 of 2022. If low response rates continue, CCBH will need to address the potential for bias in results going forward for these important measures related to its public health strategy interventions. As relates to Rating 2, IPRO recommends the following: 1) CCBH makes a somewhat strong case for expecting improvement down the line based on steady improvements in some of its ITMs which serve as useful leading indicators. On the other hand, ITMs like 1a, 1b, 2a, suggest inconsistent or unclear results, especially with newer interventions like its Recovery Management Checklist intervention. Actualization of improvements in the Sustainable Improvement year of the PIP will depend on continued effort, vigilance, and a readiness to adjust if needed.			
Performance Measures: HEDIS FUH 7- and 30-day (all ages)	CCBH and its Primary Contractors should look to some of its more successful Primary Contractors like BHARP, Blair, and Erie counties for insights on how to improve follow-up rates. Analysis may need to be measure- and even age-specific, as results suggest Primary Contractors perform relatively better or worse depending on the age cohort and whether the FUH measure is HEDIS versus PA-specific. IPRO commends CCBH's multi-pronged approach and encourages CCBH to continue with the interventions it has identified in its HEDIS FUH quality improvement plans. CCBH rates have declined in recent years, but the quality of the plans suggests recalibration as opposed to overhauling existing interventions, particularly as the new, and newly expanded, data and information become available. Given the complex scope and limited resources, a next step for CCBH and its Primary Contractors to consider is to identify the largest cohorts (however they are defined) of qualifying FUH discharges and focus on those factors that appear to be the biggest drivers of follow-up rates for those cohorts.	-	✓	✓
Performance Measures: PA FUH 7- and 30-day (all ages)	See HEDIS FUH	-	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures: REA	IPRO agrees with CCBH's assessment and proposed interventions in its REA quality improvement plan which center on expanding timely access to appropriate treatment that addresses the whole person. This includes training and supporting care management in motivational interviewing as part of its admissions and aftercare outreach interviews with members, as preliminary results from CCBH suggest that members engaging in these interviews have lower readmission rates. As with efforts to improve FUH rates, the expanded data and information should serve CCBH well in adjusting, discontinuing, and/or replacing interventions as results warrant. Critical to this will be a judicious application, based on logic models of change, of the appropriate timelines to assess before making changes.	-	✓	✓
Compliance: Availability of Services	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Coordination and continuity of care	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Coverage and authorization of services	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Practice Guidelines	Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Grievance and appeal systems	IPRO concurs with OMHSAS recommendations. It is recommended that CCBH ensure that members can meet in-person for Complaint and Grievance reviews, if they choose. Several Primary Contractors noted that in-person meetings were only being offered if a member "insists." It is recommended that member consent be obtained for all those attending a Complaint or Grievance review meeting who are not fulfilling an Appendix H required role. Prior recommendations for the triennial substandard deficiencies remain until next review.	✓	✓	✓
MBH				
PIP: Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for	As relates to Finding 1, IPRO recommends the following:	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Substance Use Disorders	1) MBH should implement at least one performance indicator of its general population (community prevention) objectives. The relative participation of CRS services among African Americans and Hispanics could serve this role for objective #6; however, the objective #5 related to prevention and early detection would seem to suggest the need for another measure. One possibility is for MBH to run an administrative measure of SBIRT or similar screening encounters, albeit one limited to its own enrolled members. This carries the advantage of being able to retroactively calculate a 2020 baseline. Another possibility is an education and outreach campaign with community- based providers and recovery supports to address the lingering stigma attached to pharmacotherapy (e.g., among certain AA groups) which would help address a barrier to improving MAT rates. Such a measure could be operationalized in the form of a survey or questionnaire. As relates to Rating 2, IPRO recommends the following: 1) MBH makes a strong case for expecting improvement down the line based on steady improvements in many of its ITMs which serve as useful leading indicators. Actualization of those improvements will however depend on continued effort, vigilance, and a readiness to adjust if needed.			
Performance Measures: HEDIS FUH 7- and 30-day (all ages)	IPRO concurs with MBH's proposed remediations outlined in its quality improvement plans which, taken together, provide a multipronged response. These include innovative VBP arrangements ranging in scope from inpatient facilities to peer and recovery support providers, automation of CM workflows with trigger points for SDOH-positive screens or other adverse results, expansion of Project RED, internal and external audits ranging from record reviews to reviews of trauma-informed care, and enhanced telehealth supports. Related to the ethnic disparity finding, IPRO recommends MBH incorporate consideration of any disparities into their root cause analyses	-	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	and quality improvement plans, even if disparities appear to favor non-majority groups, as the goal ultimately is to eliminate health care disparities in general. One way to do this is to consider including other variables in statistical models such as urban versus rural residence. This may in turn reveal deeper causes that suggest effective responses.			
Performance Measures: PA FUH 7- and 30-day (all ages)	See HEDIS FUH	-	✓	✓
Performance Measures: REA	MBH should continue to engage with its logic models of change making sure that data are being collected at appropriate frequencies along all the important points of the chains of causation so that hypotheses about what is working or not working and why can be made and tested. Insights from those analyses can then be used to inform recalibrations of interventions, or if necessary, recalibrations of the logic models themselves.	-	✓	✓
Compliance: Quality assessment and performance improvement program	IPRO concurs with OMHSAS: Corrective Action Required: Cambria should create a policy and procedure that describes the process for resolution of issues and identifies those responsible for follow-up and how the resolution of issues will be monitored to ensure responsiveness. This should clearly outline the role that the CFST program will take in this process. Furthermore, Cambria should create a policy that outlines resolution process that outlines the CFST Program's involvement in the follow-up process.	✓	✓	✓
Compliance: Grievance and appeal systems	IPRO concurs with OMHSAS's recommendations, some of which continue from last year and include: Sign-in sheets for 1st and 2nd Level Complaint and Grievance reviews must be completed for all reviews; Decision letters need to be clear and concise; follow up with members to ascertain satisfaction of process; monitor case files for completeness and report issues to Primary Contractors as needed; adhere to Appendix H timelines; improve documentation in case notes; and MBH define explicit criteria to trigger onsite provider reviews or other follow-up actions	✓	✓	✓
PerformCare				
PIP: Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for	As relates to Rating 1, IPRO recommends the following:	✓	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Substance Use Disorders	1) PerformCare should revisit its logic model of change to ensure the important points and links in its causal chains are being validly measured. In its logic mode of change, PerformCare should take into account duration as well as scope of interventions when considering likely impacts (and when those impacts should occur). 2) This should inform a review of FUI results and possibly revisiting or at least clarifying certain ITMs and possibly Indicator 6. Analysis should be carried out according its data analysis plan, and discussion should be clearly written describing and then interpreting the findings according to its logic model of change while at the same time describing any threats to internal and external validity which would aid the reader in assessing the confidence levels of those findings. 3) Furthermore, if findings suggest it, the logic model of change itself should be revisited and updated if needed. A report that clearly lays out the above considerations will then serve as a document of learning which is after all a centerpiece of a PIP. As relates to Rating 2, IPRO recommends the following: 1) While some interventions have been discontinued, new interventions in 2023, along with continued analysis of barriers to provision of psychosocial counseling (the counseling component of MAT), promise to help sustain observed improvements while addressing difficult barriers hindering improvement in initiation and engagement in specialty SUD treatment, especially MAT. Spread and sustainability of improvements, however, will depend on the extent to which the challenges noted above related to planning, execution, measurement (particularly for FUI, the Prevention Survey, and certain ITMs), analysis, and learning are addressed.			
Performance Measures: HEDIS FUH 7- and 30-day (all ages)	PerformCare and its Primary Contractors should revisit its RCA and build out a robust logic model of change that delineates a chain(s) of causes and effects based on rigorous data collection	-	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	and analysis of the barriers to improving FUH rates. The current static list of factors, in other words, needs to be operationalized into a causal model that takes into account flows of data, information, activities (e.g., workflows), resources, people, and other elements that link up in a chain of causes and effects and where those flows are typically characterized by time delays. These links and their quantitative impacts should be grounded in data. The resulting model will help identify leverage points for changing the ultimate downstream outcome-of-interest, in this case FUH rates, as appropriately stratified to address any observed racial or ethnic disparities. Importantly, the model will inform interventions that address barriers to change and measurement points along the chains to monitor progress, using appropriate timeframes, and adjust course as needed. Finally, among the resources already available to it, PerformCare should utilize the IPRO Tableau FUH Rates Report.			
Performance Measures: PA FUH 7- and 30-day (all ages)	See HEDIS FUH. PerformCare should also scrutinize their identification of denominator episodes in MY 2021 and MY 2022 to see if any issues with their algorithm or underlying enrollment or encounters data might have introduced errors in calculation of PA-specific FUH rates for MY 2021 and/or MY 2022.	-	✓	✓
Performance Measures: REA	PerformCare and its Primary Contractors should revisit its RCA and build out a robust logic model of change that delineates a chain(s) of causes and effects based on rigorous data collection and analysis of the barriers to reducing REA rates. The current static list of factors, in other words, needs to be operationalized into a causal model that takes into account flows of data, information, activities (e.g., workflows), resources, people, and other elements that link up in a chain of causes and effects and where those flows are typically characterized by time delays. These links and their quantitative impacts should be grounded in data. The resulting model will help identify leverage points for changing the ultimate downstream outcome-of-interest, in this case REA rates, as appropriately stratified to address any observed racial or ethnic disparities. Importantly, the model will inform interventions that address barriers to change and measurement points	-	✓	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
	along the chains to monitor progress, using appropriate timeframes, and adjust course as needed. Finally, among the resources already available to it, PerformCare should utilize the IPRO Tableau REA Rates Report.			
Compliance: Availability of Services	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Coordination and continuity of care	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Coverage and authorization of services	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	✓	✓	✓
Health Information Systems	A Corrective Action Plan has been assigned by OMHSAS to remediate.	✓	✓	✓
Compliance: Practice Guidelines	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	✓	✓	✓
Compliance: Grievance and appeal systems	Prior recommendations for the noted triennial substandard deficiencies remain until next review.	✓	✓	✓

MCO: managed care plan; EQR: external quality review; PIP: performance improvement project; SFY: state fiscal year;

CHC-MCO EQR Recommendations

Table 104: CHC-MCO EQR Recommendations

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
CHC-MCO – ACP				
PIPs	There are no recommendations related to the PIP submissions for the current RY.	-	-	-
Performance Measures	It is recommended that the MCO improve rates for annual dental visits, immunizations, and cervical cancer screening.	✓	-	✓
Performance Measures	It is recommended that the MCO improve rates for care coordination and LTSS measures.	✓	-	✓
Performance Measures	It is recommended that the MCO improve appropriateness and overuse of prescription opioids.	-	-	✓
Compliance: Coordination and continuity of care	The MCO should improve the transfer of information and records to ensure a seamless transition for participants switching CHC-MCOs.	✓	✓	✓
CHC-MCO – KF				
PIPs	There are no recommendations related to the PIP submissions for the current RY.	-	-	-
Performance Measures	It is recommended that the MCO improve rates for annual dental visits and immunizations.	✓	-	✓

Measure/Project	IPRO's Recommendation	Quality	Timeliness	Access
Performance Measures	It is recommended that the MCO improve behavioral health measures rates.	✓	-	✓
Performance Measures	It is recommended that the MCO improve care coordination as it relates to transitions of care and LTSS.	✓	✓	✓
Compliance: Coordination and continuity of care	The MCO should improve the transfer of information and records to ensure a seamless transition for participants switching CHC-MCOs.	✓	✓	✓
CHC-MCO – PHW				
PIPs	There are no recommendations related to the PIP submissions for the current RY.	-	-	-
Performance Measures	It is recommended that the MCO improve rates for annual dental visits, cardiovascular care, kidney health and diabetes care, and immunizations.	✓	-	✓
Performance Measures	It is recommended that the MCO improve measure rates as it relates to care coordination, transitions of care, and LTSS.	✓	✓	✓
Performance Measures	It is recommended that the MCO improve measure rates for appropriateness of antibiotic treatment and overuse of prescription opioids.	-	-	✓
Compliance: Coordination and continuity of care	The MCO should improve the transfer of information and records to ensure a seamless transition for participants switching CHC-MCOs.	✓	✓	✓
CHC-MCO – UPMC				
PIPs	There are no recommendations related to PIP submissions for the current RY.	-	-	-
Performance Measures	It is recommended that the MCO improve measure rates for annual dental visits, diabetes care, and respiratory care.	✓	-	✓
Compliance with Medicaid and CHIP Managed Care Regulations	There are no recommendations related to compliance for the MCO.	-	-	-

EQR: external quality review; PIP: performance improvement project; CHIP: Children's Health Insurance Program; MCO: managed care organization; NCQA: National Committee for Quality Assurance; PM: performance measure.

The CHC-MCO P4P Matrix provides a comparative look at selected measures and indicators included in the Quality Performance Measures component of the Community 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 and indicates possible opportunities for improvement for the CHC-MCOs.

Figure 3 displays the P4P measures for each CHC-MCO.

Rating	ACP-CHC	KF-CHC	PHW-CHC	UPMC
D	Reassessment and Care Plan Update After Inpatient Discharge PCSP Included All Things Important to You	Overall Satisfaction with Health Plan PCSP Included All Things Important to You	No measures fell into this category.	PCSP Included All Things Important to You Number of participants who successfully transitioned from the NF to the community
F	No measures fell into this category.	Shared Care Plan with Primary Care Practitioner	PCSP Included All Things Important to You	No measures fell into this category

Figure 3: CHC-MCO P4P Measure Root Cause Analysis and Action Plan

X. Adult Community Autism Program (ACAP)

Introduction

The Adult Community Autism Program (ACAP) is a voluntary PIHP program approved under the authority of 1915(a) of the Social Security Act and is overseen by ODP. ACAP is designed to meet the needs of adults with ASD. The program is administered under the "Agreement for the Adult Community Autism Program (ACAP)" ("Agreement") with Keystone Autism Services (KAS). KAS provides ambulatory medical services and LTSS to the adults enrolled in the program. As of September 2023, 188 members were enrolled in the program.

Performance Improvement Project

Objectives

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

Technical Methods of Data Collection and Analysis

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

- Project Topic
- Methodology
- Barrier Analysis, Interventions, and Monitoring
- Results
- Discussion

IPRO's validation of PIP activities is consistent with the protocol issued by CMS and meets the requirements of the Final Rule on the EQR of Medicaid MCPs. IPRO's review evaluates each project, as they are reported using an annual form, for compliance with the 8 review elements listed below:

1. Topic Rationale
2. Aim
3. Methodology
4. Identified Study Population Barrier Analysis
5. Robust Interventions
6. Results
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each applicable element is scored as either meeting or not meeting the requirement. Based on review of the listed elements, IPRO provides two qualitative assessments of the PIP, expressed in terms of levels of confidence (High, Moderate, and Low or None): 1) EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases; and 2) EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement.

The "Reducing Social Isolation" which focused on mitigating and overcoming social isolation among ACAP members, was extended in 2022, due in part to the lower than expected participation rate of ACAP members in the PIP intervention. 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 was utilized on a quarterly basis to record members' perceptions of social isolation, companionship, and community participation. The principal intervention featured a person-centered social role valorization (SRV) model that sets goals for attaining socially valued roles (SVR). Intervention tracking measures (ITMs) center on measurement using a Goal Attainment Scale (GAS). Two performance indicators are based on the Social Isolation tool: a Social Isolation (SI) Index score which measures the average social isolation of ACAP members (Indicator 1), and the percentage of members reporting feeling socially isolated (Indicator 2).

2022 coincided with the fourth and final year to demonstrate "Sustainable Improvement." A final report was submitted to IPRO in September 2023, and IPRO reviewed the results and assessed for validity.

Findings

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

Based on review of KAS's Final report, there is moderate confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results. Insufficient discussion was given to the data system challenges associated with CareLogic and QuestionPro alone which threatened systematically undercounting the number of individuals completing the 10-step process, further introducing "noise" in the data and complicating any attempt to link intervention activities with downstream outcomes. Discussion was clarified by focusing on Difference-in-Difference (DiD) test results. That said, definition of what constituted "treatment" remained ambiguous—was it defined as participating in person-centered planning (PCP) at all, or by the extra (more meaningful) criterion of having a defined SVR objective?—and therefore findings were correspondingly difficult to interpret.

KAS to its credit laid out many of the lessons learned and steps taken to-date to address them, which have included the inception of a new intervention and monitoring of SRV model fidelity. However, numerous questions remain after this review about the extent to which previously noted issues have been addressed. Documentation related to service planning and provision remained prone to error. It was also not clear that staff were at the point of fully implementing the SRV model using the newly developed 10-step structure. More measurements on completion rates of the 10-step process would be needed to assess this. As previously stated, though, criteria for comparison groups also needed to be further clarified with respect to what constitutes treatment. Moreover, in its analysis, KAS did not compare social isolation scores among participants in the PIP with respect to several potentially confounding factors such as employment status, ACAP tenure, and county-of-residence. KAS reported that it is exploring possibly examining such linkages in the future. Analysis and discussion would have benefitted from taking the next logical step, namely: testing for correlation between these factors and social isolation and then, for each factor that is found to be statistically significantly associated with social isolation, testing to see if it also correlates with participation in the PIP intervention (or not).

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

There is moderate confidence that the PIP produced evidence of significant improvement. When viewed over the entire PIP, Indicator 1 was steadily improving for all ACAP members until 2022, when only those with a SVR objective ("cohort B") improved. This suggests sustained improvement of not only those participating but of the intervention itself but "noise" from natural variation in the data could not be ruled out. In contrast, Indicator 2 steadily worsened (increased) since Year 2. The DiD results certainly suggest a possible treatment effect, and this should have been discussed more by KAS, particularly in discussing potential factors behind this albeit more limited "success." Indeed, some of KAS's observations suggest that population-average improvement on the performance indicators did not seem to correlate with aggregate progress on the GAS or

achievement of socially valued roles (SVR), suggesting the observed improvement in the indicators were driven by other factors.

With respect to Rating 1 and 2, IPRO recommends the following:

- Considering that, as of Q2 of Year 4, not quite 75% of members had participated in the PIP, it is reasonable to presume that overall indicators would have improved. Furthermore, improvements in both SRV model fidelity, starting with the 10-step design itself, along with continued implementation of intervention 2 (which was prematurely ended), combined with better measurement and clearer criteria defining "treatment" would go a long way toward leveraging the lessons learned to-date and ultimately building a sustainable component of the ACAP program that addresses the important needs associated with social isolation of its members.

Performance Measures

Objectives

For MY 2022, ODP required KAS to calculate and report performance measures as part of their quality assessment and performance improvement (QAPI) program. IPRO validated all performance measures reported by the PIHP for MY 2022 to ensure that the performance measures were implemented according to specifications and state reporting requirements (*Title 42 CFR § 438.330(b)(2)*).

Technical Methods of Data Collection and Analysis

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

For MY 2022, six performance measures were used by ODP to monitor KAS' QAPI program with respect to key health outcomes and for which benchmarks were established:

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

Annual results were submitted by KAS to ODP in their annual ACAP ODP Report which covered the 2023 state fiscal year (SFY) spanning from July 1, 2022-June 30, 2023. As part of its annual compliance review, ODP reviewed documentation related to KAS' tracking and reporting of the six performance measures. ODP also reviewed a sample of participant records, including: individual service plans (ISP), assessments, incident reports, service records, encounter forms, and medical records, along with other primary data as part of its monitoring for MY 2022. KAS was found partially compliant with requirements related to QAPI reporting.

Findings

MY 2022 results are reported in **Table 105**.

Table 105: ACAP Results for 2023 (MY 2022) Performance Measures

Performance Measure	Benchmark	Rate
Law Enforcement Incidents	95% of all individuals will reduce or maintain, if at zero, their number of law enforcement incidents (charged with a crime or under police investigation) as compared to baseline	98.3% (177 of 180)
Behavioral Health Crisis Events	95% of all individuals will reduce or maintain, if at zero, their number of behavioral health crisis events as compared to baseline	95% (171 of 180)
Psychiatric Hospitalization Follow-up	95% of all psychiatric hospitalizations will be followed by a psychiatric or PCP visit within 30 days	100% (8 of 8) of psychiatric hospitalizations
(Timeliness of) Initial Primary Care Physician (PCP) Visit	95% of all new enrollees will have an initial visit with a PCP within 3 months prior to enrollment or within 3 weeks after enrollment	57.1% (4 of 7)
Annual Dental Exam	90% of all participants will have a dental exam each calendar year	80.1% (145 of 181)
Competitive Employment	56% of participants will be employed	57.4% (108 of 188) of participants were employed in December 2022

KAS Compliance with Medicaid Managed Care Regulations

Objectives

This section of the EQR report presents a review by IPRO of the PIHP's compliance with the MMC structure and operations standards. Updates to the CMS EQRO Protocols released in 2023 included updates to the 13 BBA standards which are now required for reporting. The standards that are subject to EQR review are contained in *Title 42 CFR § 438*, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E.

Technical Methods of Data Collection and Analysis

ODP provided IPRO with SFY 2023 monitoring findings spanning from July 1, 2022-June 30, 2023. These findings were supplemented with IPRO's MY 2021 compliance review of KAS which was completed in 2022 and covered areas under a triennial review cycle. The thirteen required standards covering these Subparts are comprised of CMS review elements which were furthermore crosswalked to pertinent standards defined in the ACAP Contract, or "Agreement." Compliance review for MY 2021 consisted of KAS submitting requested documentation (including case review files), a process which underwent several iterations to ensure relevance and completeness of information, followed by a desk review by IPRO and finally a virtual video conference with KAS leadership and staff consisting of document and system reviews and informal interviews. MY 2022 findings of review elements under annual review were updated by ODP's 2023 annual monitoring report.

For MY 2022, both ODP and KAS had the opportunity to review initial compliance review determinations and respond with clarifications before final determinations were made.

Findings

Tabulated findings are formatted to be consistent with the subparts prescribed by the BBA regulations. In addition, findings for MY 2022 are presented here under the three "CMS sections" headings: Standards,

including Enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up were also produced. Applicable regulatory requirements are summarized under each programs' subsections, consistent with the applicable subparts set out in the BBA regulations and described in the *MCP Monitoring Protocol.*

Table 106 summarizes the compliance review determinations across the 13 BBA MMC standards with tallies of the applicable compliance review elements that were used, by finding. Compliance level of "Met," "Partially Met," and "Not Met" were used. Separate tallies are provided for elements that are not applicable ("N/A") or deemed compliant from a secondary source review, such as an NCQA-accreditation("Deemed").

Table 106: KAS Compliance with MMC Standards in MY 2022

MMC Standard	Compliance Status	N/A	Deemed	Met	Partially Met	Not Met
Standards, including enrollee rights and protections						
Assurances of adequate capacity and services (*Title 42 CFR § 438.207*)	Partially Met	0	0	5	12	5
Availability of services (*Title 42 CFR § 438.206 and § 10(h)*)	Partially Met	1	0	9	13	3
Coordination and continuity of care (*Title 42 CFR § 438.208*)	Partially Met	0	0	33	18	44
Coverage and authorization of services (*Title 42 CFR § 438.210(a–e), § 441, Subpart B, and § 438.114*)	Partially Met	0	0	23	32	18
Disenrollment requirements and limitations *Title 42 CFR § 438.56*	Met	0	0	9	0	0
Emergency and post-stabilization services *Title 42 CFR § 438.114*	Partially Met	0	0	1	1	0
Enrollee rights and protections *Title 42 CFR § 438.100*	Partially Met	12	0	56	6	2
Health information systems (*Title 42 CFR § 438.242*)	Partially Met	0	0	3	1	0
Practice guidelines (*Title 42 CFR § 438.236*)	Partially Met	0	0	4	3	1
Provider selection (*Title 42 CFR § 438.214*)	Partially Met	0	0	7	31	2
Subcontractual relationships and delegation (*Title 42 CFR § 438.230*)	N/A	5	0	0	0	0
Quality assessment and performance improvement (QAPI) program						
Quality assessment and performance improvement program (*Title 42 CFR § 438.330*)	Partially Met	1	0	6	16	1
Grievance system						
Grievance and appeal systems (*Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424*)	Partially Met	0	0	42	0	1

KAS was found partially compliant with nine of the eleven standards within Standards, including Enrollee rights and protections. A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. Case management file reviews also revealed some specific opportunities for improvement. Under Coordination and continuity of care, it was noted that KAS should ensure that Medication Therapeutic Management Plans are developed for members with four (4) or more psychotropic medications. For Coverage and authorization of services, IPRO recommended KAS stand up a tracking mechanism for all elements of authorization cases including timeliness, information on phone calls, and all correspondence. Many of the findings from IPRO's 2022 (MY 2021) compliance review still hold for MY 2022. However, KAS already started addressing some of the above

deficiencies in 2023, particularly with regard to formalizing and implementing policies and procedures for the impacted areas. Results of these efforts will be reflected in the 2024 (MY 2023) ATR next year.

For MY 2022, KAS fully met Disenrollment requirements and limitations, which was a new reporting category effective MY 2022. KAS was also reviewed for compliance with the new reporting category Emergency and post-stabilization services, and KAS was found to be partially compliant with one of the two review elements under this category. Although emergency and post-stabilization services are stipulated in the Contract/Agreement, these services were not addressed in KAS's 2022 Service Authorization Policy. As discussed under Network Adequacy Validation (NAV), while KAS was evaluated for compliance with, and met, certain emergency and poststabilization services standards in 2022, these services were not included in ODP's network adequacy monitoring for 2022, so a determination could not be made whether there was a sufficient number of post-stabilization providers in or out of network where coverage was provided.

For some of the deficiencies under Enrollee rights and protections, it was noted that remediation may in certain circumstances—for example, providing public-facing information on network adequacy standards to potential enrollees—require coordination with ODP, possibly including updates to the existing Agreement, to ensure alignment. The current Agreement prohibits KAS from delegating any functions; KAS was therefore exempt from review for Subcontractual relationships and delegation.

KAS was partially compliant with QAPI. Many of MY 2021 findings held for MY 2022. In a theme that cut across all three major compliance areas, many deficiencies center on a lack of formal policies, procedures, or plans. It was noted that KAS needed to update its QAPI plan to measure, evaluate, and monitor quality areas as outlined in the Agreement. Among other things, KAS should expand utilization reporting to all services including medical and BH services provided in the larger network, and should cover all utilization, not just those above a certain threshold. This means developing methods for detecting over-, under-, and misutilization for services covered (i.e., paid for, either in part or in full), and not just provided, by KAS. Finally, the monitoring mechanism should be formalized in writing, as part of its QAPI plan. Related to this, it was noted that no audits of medical and support service records had been conducted by KAS in 2021, as required in the Agreement. The review furthermore recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement. Other recommendations from MY 2021 centered on governance. KAS should implement a formal governance process that ensures that adequate support, including staff and alternative forms of communication, is provided to the Participant Committee and its report-out to the Member Advisory Committee (MAC). Furthermore, KAS should implement a formal governance process that ensures that adequate support is provided by the MAC to the Quality Management and Utilization Review Committee(s) and furthermore that the MAC is accountable to the relevant governing body for issues addressed by the Quality Management and Utilization Review Committee(s). Finally, KAS should implement a formal policy that the Quality Management and Utilization Review Committee provide guidance and assistance to support KAS in carrying out the relevant quality management responsibilities specified as specified in the Agreement. Documentation should show follow-through that reflects the guidance and assistance was taken into consideration and utilized. As previously noted, KAS reported that they were addressing some of the above deficiencies in 2023, particularly with regard to formalizing and implementing policies and procedures for the impacted areas. Results of these efforts will be reflected in the 2024 (MY 2023) ATR.

Of note, several recommendations related to QAPI were also submitted to ODP. IPRO's assessment is that the ACAP PIHPs, in this case KAS, fit the definition of "providing long-term services and supports," as provided under *Title 42 CFR § 438.330(c)(1)(ii)*. As such, a recommendation from the MY 2021 findings is that ODP should add relevant LTSS PM(s) to its QAPI PM reporting requirements. ODP did update its PM measure set in MY 2022, and they continue to explore PM development that will meet both Federal standards as well as State

Quality Strategy and ACAP goals. More generally, IPRO recommends the Agreement continue to be updated to reflect changes in both Federal and ODP standards, including as they pertain to PIPs.

KAS was partially compliant with one requirement under Grievance system. Consistent with the general theme of formalizing policies, it was recommended that KAS add to the Compliant and Grievance Procedure and the Participant Handbook that clarifies a requirement regarding filing a discrimination complaint with the Office of Civil Rights. KAS is required to align its Participant Handbook to the required standard State MCP Handbook, so any changes related to the Participant Handbook will need to be coordinated through ODP.

Network Adequacy Validation

Objectives

As set forth in *Title 42 CFR § 438.358*, validation of network adequacy is a mandatory EQR activity. *Title 42 CFR § 438.68(a)* requires states that contract with an MCP to deliver services develop, monitor, and enforce network adequacy standards consistent with the requirements under *Title 42 CFR § 438.68(b) (1)(iii)* and *457.1218*. The EQRO is expected to validate network adequacy reporting for each MCP that assesses the confidence level of network adequacy findings for each applicable standard. EQRO validation is limited to assessment of the validity of network adequacy findings and does not include assessment of the network adequacy standards themselves. The purpose of this section is to report the EQRO's validation assessment of network adequacy findings for the PIHP, in this case, KAS. In accordance with the updates to the Centers for Medicare and Medicaid Services (CMS) EQRO Protocols released in February 2023,[23] the EQRO is to conduct six activities, as outlined in **Table 107**.

Table 107: Network Adequacy Validation Activities

Activity	Category
Define the scope of the validation	Planning
Identify data sources for validation	Planning
Review information systems	Analysis
Validate network adequacy	Analysis
Communicate preliminary findings to MCP	Reporting
Submit findings to the state	Reporting

Starting in February 2024, states must have in place a network adequacy monitoring and reporting program that stipulates state standards for the applicable plan type and corresponding quantitative indicators for network adequacy and collects data, analyzes those data, and reports findings on network adequacy on a regular basis. Regardless of whether network adequacy monitoring and reporting is conducted by the MCP or the state, the EQRO is expected to assess the validity of data collected on each applicable indicator as well as the validity of the analyses and resulting findings. While MY 2022 predates the publication of the February 2023 protocol, IPRO was able to work with PA ODP on the six EQR activities. These activities enumerated the relevant standards and corresponding indicators that were in effect in MY 2022, collected MY 2022 results, and, finally, assessed the validity of those results.

Technical Methods of Data Collection and Analysis

IPRO gathered information from PA ODP to conduct preliminary network adequacy validation activities using worksheets 4.1, 4.2, and 4.3 of the 2023 CMS EQR Protocols. PA ODP completed the three worksheets, which listed and described: the network adequacy standards that were in effect for the MY (Worksheet 4.1), the

[23] Centers for Medicare & Medicaid Services (CMS). (2023, February). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. CMS External Quality Review (EQR) Protocols (medicaid.gov)

quantitative indicators used to assess compliance with the network adequacy standards (Worksheet 4.2), and the data source(s) used for each indicator (Worksheet 4.3). IPRO supplemented this information using results from its Health Information Systems review it conducted on KAS in 2022. Using this information, IPRO then assessed the data sources and data collection procedures for validity, including measurement validity, accuracy, and completeness.

Description of Data Obtained

Table 108 summarizes the state network adequacy standards that were reported as applicable to KAS in MY 2022, the frequencies of data-reporting by the PIHP, and corresponding network adequacy indicators. Of note, although Inpatient and Residential Services were indicated in the Quality Strategy as being subject to time and distance standards (**Table 70**), this category of service was not measured by ODP on its corresponding network adequacy indicator. **Table 72** lists provider types which ODP should monitor for compliance with wait time standards by a formal metric. In MY 2022, ODP did include in its annual monitoring review of compliance on relevant standards by specific categories of service such as emergency and post-stabilization services.

Table 108: PIHP Network Adequacy Standards and Indicators Applicable in MY 2022

Network Adequacy Standard	Applicable Provider Type	Data and Documentation Submitted by MCP (frequency)	Network Adequacy Indicator
The Contractor must offer Participants a choice of at least two (2) Network Providers for each service or Provider type. Providers must be within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	Dental	Submitted annually in PDF-only format to a designated SharePoint location	Proportion of participants who have (at least) two providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.
	OB-GYN	Submitted annually in PDF-only format to a designated SharePoint location	
	PCP	Submitted annually in PDF-only format to a designated SharePoint location	
	Vision	Submitted annually in PDF-only format to a designated SharePoint location	

Findings

One network adequacy indicator for each applicable provider type was used by ODP to measure compliance on the network adequacy standard that was in place in MY 2022 related to time and distance. For its monitoring, KAS utilizes its electronic health record system to generate a list of enrollees with zip code of residence. KAS also relies on a provider tracking file to identify current network providers and extract information on provider type and location. These data are then imported into the Quest Analytics Suite software which applies longitude/latitude geo coding to those data to produce a geo access report. The vendor, Quest Analytics, provides technical support as needed. KAS reviews all the reports to confirm all participants and providers are captured accurately. KAS then submits the geo access reports to a secure Sharepoint location hosted by PA ODP which subsequently retrieves and reviews the reports. The reports for

the four provider types enumerated in **Table 108** were shared with IPRO as part of this review. **Table 109** summarizes the results of the geo access summary reports, by provider type.

Table 109: PIHP Network Adequacy Results for MY 2022

Network Adequacy Standard	Network Adequacy Indicator	Applicable Provider Type	% of members where standard was met
The Contractor must offer Participants a choice of at least two (2) Network Providers for each service or Provider type. Providers must be within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	Proportion of participants who have (at least) two providers within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas.	Dental	95.6%
		OB-GYN	72.0%
		PCP	99.5%
		Vision	76.4%

The reports are then reviewed for access needs that are below standard. For areas where access is not within requirements, KAS continues to work on identifying MA providers to bring in-network, although it noted that this can be a challenge, given the relatively small size of the ACAP program.

After review of the relevant MY 2021 Health Information System findings, network adequacy data and methods, IPRO has high confidence in the validity of these MY 2022 results.

As of 2024, unless as noted below, ODP had applied the time and distance standard requiring at least two providers operating within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas, to the following provider types:

- Physician Services
- Audiologist
- CRNP
- Chiropractor
- Dentist
- Health Promotion
- Hospice
- ICF (at least two providers, one of which must be operating within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas)
- Medical Supplies/DME
- Mental Health Crisis Intervention
- Non-emergency Transportation
- Nursing Facility (at least two providers, one of which must be operating within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas)
- Optometrist
- Psychiatric (Outpatient)

- Podiatrist
- Prosthetic Eye/Other Eye Appliances
- Respiratory
- TCM
- Assistive Technology
- Career Planning
- Community Transition Services
- Day Habilitation
- Family Support
- Homemaker/Chore
- Home Modifications
- Non-Medical Transportation
- Nutritional Consultation
- Personal Assistance
- Residential Habilitation (at least two providers, one of which must be operating within thirty (30) minutes travel time in urban areas and within sixty (60) minutes travel time in rural areas)
- Respite
- Small Group Employment
- Supported Employment
- Specialized Skill Development
- Therapies
- Vehicle Modifications
- Visiting Nurse

ODP continues to work on expanding its network adequacy monitoring program, including expansion of reporting to include all provider types falling under the applicable network adequacy standards.

Assessment of Quality, Timeliness, and Access

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

Table 110 details the full list of recommendations that are made for the PIHP for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for the measurement year. The PIP recommendations may include issues from prior years if they remain unresolved. For performance measures, the strengths and opportunities noted above in this section apply to MY 2022, while recommendations are based on issues that were not only identified as opportunities for MY 2022 but were also identified as outstanding opportunities from MY 2021.

Table 110: ACAP EQR Findings and Recommendations

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
Performance Improvement Projects (PIPs)				
PIPs	The review noted that the formal education and training intervention	Based on review of KAS's final report, there is moderate confidence	As relates to Rating 1, IPRO recommends the following: Improvements	Quality, Timeliness, Access

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
	around the new process was limited to April and May of 2021. IPRO cautioned KAS against prematurely concluding that this intervention had achieved its full effect and recommended KAS continue with the education and training intervention and monitor it using effective ITMs concerned with measuring activities as well as downstream learning outcomes, for example, via the Service Review Form (SRF), or similar periodic internal quality reviews. Improvement on the performance indicators has not yet been demonstrated. There may be characteristics associated with the self-selected treatment cohort which correlate with improvement, and this self-selection bias cannot be more fully tested until all ACAP members participate in the PIP intervention. As of the end of 2021, 117 out 183 members, or roughly 64%, had participated in the PIP, of which 56.4% had undergone the full 10-step SRV process. IPRO urged KAS to accelerate member participation rates in the PIP, noting that the PIP's intent and design called for full participation by the conclusion of the PIP in summer 2023.	that the PIP adhered to acceptable methodology for all phases of design and data collection, data analysis, and interpretation of PIP results (Rating 1). The DiD results certainly suggest a possible treatment effect, and this should have been discussed more by KAS, particularly in discussing potential factors behind this albeit more limited "success." When one considers that, as of Q2 of Year 4, not quite 75% of members had participated in the PIP, it is reasonable to presume that overall indicators would have improved. There is moderate confidence that the PIP produced evidence of significant improvement (Rating 2). When viewed over the entire PIP, indicator 1 was steadily improving for all ACAP members until last year, when only those with a SVR objective ("cohort B") improved. This could be due to data "noise," but perhaps it reflects sustained improvement of not only those participating but of the intervention itself. In contrast, indicator 2 has been steadily worsening (increasing) since Year 2.	in both SRV model fidelity, starting with the 10-step design itself, along with continued implementation of intervention 2 (which was prematurely ended), combined with better measurement (and clearer definition of criteria for "treatment") would go a long way toward leveraging the lessons learned to-date and ultimately building a sustainable component of the ACAP program that addresses the important needs associated with social isolation of its members.	
Performance Measures				
PMs	ODP should add relevant LTSS PM(s) to its QAPI PM reporting requirements. It	In 2023, ODP proposed changes to the QAPI PM set in Appendix K,	The previous recommendation remains that ODP should	Timeliness, Access

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
	was noted that KAS needed to update its QAPI plan to measure, evaluate, and monitor quality areas as outlined in the Agreement (Appendix K).	including possible alignment with national measures. KAS created and filled a quality manager position in 2023 to oversee implementation of their QAPI program. It is expected that this will help ensure oversight of PM reporting.	add relevant LTSS PM(s) to its QAPI PM reporting requirements. IPRO communicated that program offices, including ODP, should set goals for their QAPI PMs consistent with its quality strategy and as relates to the DHS Quality Strategy.	
Compliance with Medicaid Managed Care Regulations				
Assurances of adequate capacity and services	Formalize policies, procedures, and plans.	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.	Previous recommendations still hold.	Quality, Timeliness, Access
Availability of Services	Formalize policies, procedures, and plans. The review furthermore recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement.	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.	Previous recommendations still hold.	Quality, Timeliness, Access
Coordination and continuity of care	Formalize policies, procedures, and plans. KAS should ensure that Medication Therapeutic Management Plans are developed for members	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to	Previous recommendations still hold.	Quality, Timeliness, Access

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
	with four (4) or more psychotropic medications. The monitoring mechanism should be formalized in writing, as part of its QAPI plan. Related to this, it was noted that no audits of medical and support service records had been conducted by KAS in 2021, as required in the Agreement. The review furthermore recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement.	ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.		
Coverage and authorization of services	KAS should stand up a tracking mechanism for all elements of authorization cases including timeliness, information on phone calls, and all correspondence.	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.	Previous recommendations still hold.	Timeliness, Access
Emergency and post-stabilization services	This standard was not reported for MY 2021.	Not applicable; this standard was not reported for MY 2021.	ODP should include in its monitoring of emergency and post-stabilization services an explicit assessment of KAS's network adequacy for this service.	
Enrollee rights and protection	Remediation may in certain circumstances—for example, providing public-facing information on network adequacy standards to potential enrollees—require coordination with ODP, possibly including updates	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position	Previous recommendations still hold.	Quality, Timeliness, Access

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
	to the existing Contract, to ensure alignment.	whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.		
Health information systems	Formalize policies, procedures, and plans.	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.	Previous recommendations still hold.	Quality
Practice guidelines	Formalize policies, procedures, and plans.	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.	Previous recommendations still hold.	Quality, Timeliness, Access
Provider selection	Formalize policies, procedures, and plans.	A majority of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards.	Previous recommendations still hold.	Quality, Timeliness, Access

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
Quality assessment and performance improvement program	Among other things, KAS should expand utilization reporting to all services including medical and BH services provided in the larger network, and should cover all utilization, not just those above a certain threshold. This means developing methods for detecting over-, under-, and misutilization for services covered (i.e., paid for, either in part or in full), and not just provided, by KAS. Finally, the monitoring mechanism should be formalized in writing, as part of its QAPI plan. The review furthermore recommended that KAS update its audit tools to cover timely access to care and services as specified in the Agreement. Other recommendations centered on governance. KAS should implement a formal governance process that ensures that adequate support, including staff and alternative forms of communication, is provided to the Participant Committee and its report-out to the Member Advisory Committee (MAC). Furthermore, KAS should implement a formal governance process that ensures that adequate support is provided by the MAC to the Quality Management and Utilization Review Committee(s) and furthermore that the MAC is accountable to the relevant governing body.	Many of the deficiencies noted across the standard areas centered on lack of formal policies, procedures, or plans to ensure compliance with requirements. KAS created and filled a quality manager position whose responsibilities will include documenting policies, plans, and procedures for relevant compliance standards. KAS needs to update its QAPI plan to measure, evaluate, and monitor quality areas as outlined in the Agreement (Appendix K). The quality manager will oversee implementation of their QAPI program. It is expected that this will help ensure oversight of PM reporting. Related to this, it was noted that no audits of medical and support service records had been conducted by KAS in 2021, as required in the Agreement.	Previous recommendations still hold.	Quality, Timeliness, Access

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
	for issues addressed by the Quality Management and Utilization Review Committee(s). Finally, KAS should implement a formal policy that the Quality Management and Utilization Review Committee provide guidance and assistance to support KAS in carrying out the relevant quality management responsibilities specified as specified in the Agreement. Documentation should show follow-through that reflects the guidance and assistance was taken into consideration and utilized.			
Grievance and appeal systems	KAS should add to the Compliant and Grievance Procedure and the Participant Handbook that clarifies a requirement regarding filing a discrimination complaint with the Office of Civil Rights. KAS should furthermore coordinate with ODP to ensure the requirement language aligns with the standard State MCP Handbook currently in use.	KAS did not clarify in the Compliant and Grievance Procedure and the Participant Handbook a requirement regarding filing a discrimination complaint with the Office of Civil Rights.	Previous recommendations still hold.	Quality, Timeliness, Access
Network Adequacy	Network Adequacy Validation was not reported for MY 2021.	Not applicable; Network Adequacy Validation was not reported for MY 2021.	IPRO recommends ODP implement its network adequacy indicators for its existing standards, including time and distance indicators for all applicable provider types covered under ACAP including inpatient, emergency and post-stabilization, and LTSS services. ODP should also develop additional standards for appointment wait times,	

Measure/Project	MY 2021 Recommendations	MY 2022 Finding	MY 2022 Recommendations	Domains
			physical and cultural accessibility and implement corresponding indicators.	

XI. Appendix A

PH Performance Improvement Project Interventions

As referenced in **Section I: Performance Improvement Projects, Table A1** lists all of the interventions outlined in the PH-MCOs' most recent PIP submissions for the review year. The interventions are taken verbatim from the PH-MCOs' PIP reports.

Table A1: PH-MCO PIP Interventions

Summary of Interventions
PH-MCO – ACP – PIP 1: Preventing Inappropriate Use or Overuse of Opioids
1. Care Managers will outreach and educate the members with risk of continued use of opioids after 15 days (in a 30 day period) or 31 days (in a 62 day period). Outreach will be via phone and/or letter.
2. Bright Start maternity team will offer a home visitation program for all African American pregnant women with Opioid Use Disorder.
3. Emergency Room overdose follow-up: Rapid Response Outreach Team will make telephonic outreach to members identified through Health Information Exchanges, who have been to the Emergency Department with a diagnosis of overdose to assist with coordination of care and referral to appropriate resources.
4. ACP community facing teams will attempt to obtain consent forms from members with opioid use disorder when working with members in the community face to face.
5. Outreach to providers of members that are on both Opioids and Benzodiazepines.
6. Outreach to members newly initiated on buprenorphine to provide education and support to ensure adherence to prescribed regimen.
PH-MCO – ACP – PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
1. ED High Utilizer Outreach is generated for high ED utilizers following an ED visit notification through various reporting mechanisms. A Care Connector calls member, assesses needs, provides alternatives to ED, addresses barriers, and assists with making follow up appt. with PCP and/or specialist.
2. Rapid Response team to educate caregivers on appropriate use of Emergency Department and provide information on services available to be used instead of going to the ED.
3. Transition of Care Pathway: Care Manager outreaches to members discharged from Inpatient hospitalization. Care Manager completes medication reconciliation, provides education regarding condition, follow up care, assists with making follow up appointments and coordinates transportation to appointments if necessary.
4: City Life: Members will be able to schedule a telehealth appointment with a doctor when unable to access their own doctor. Availability of the program will be communicated to members by Care Managers, Acute Care Transition (ACT) nurses embedded within hospital emergency departments, and the health plan Rapid Response Outreach Team (RROT). Upon completion of appointment, City Life will provide a summary of the telehealth appointment to the member's primary care provider, who will be able to coordinate further follow-up as needed.
5. Diabetes Pathway for members with SPMI. Members with a diagnosis of SPMI and diabetes will be assigned to a Care Manager to assess member's needs and barriers, educate member on condition, medications, PCP visit schedule/screening measures, assists in resolving barriers. Focus will be on African American population.

Summary of Interventions
PH-MCO – GEI – PIP 1: Preventing Inappropriate Use or Overuse of Opioids
1. Pharmacy and Medical Director review weekly members who fill a prescription for an opioid and then later fill a prescription for suboxone. The pharmacists and medical director assess the appropriateness of therapy. Medical director outreach is made if potentially inappropriate prescribing practices or trends are identified.
2. Case Management (addiction Coordinator) referral for outreach to members following an ED visit with an OUD diagnosis. Additionally, we have Certified Recovery Specialists available to meet with members at the ED if needed.
PH-MCO – GEI – PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
1a. Automated referral to Community Health Assistants for member outreach triggered by an ED visit with a LANE (low acuity non emergent) diagnosis who have had 3 or more ED visits in the last 6 months. Member education, home, and community visits, assisting members with connecting to primary and specialty care. Address SDOH needs. Escalate to other members of the care team as indicated. The CHAs are providing additional education on accessing appropriate care at the ED/Urgent Care/PCP. Evaluating barriers to accessing appropriate care and assisting members with accessing resources to overcome these barriers to care. The CHAs are escalating members to the additional Care team members such as RN Case Managers or Behavioral Health Case Managers for additional clinical intervention. In 2020 GHP Care Management screened approximately 2,300 members for SDOH needs. Over 500 members indicated difficulty with affording food, housing, and transportation. 1b. Referral to Behavioral Health Care Management team for members with 2 or more ED visits in the last 6 months with a primary mental health or substance use disorder diagnosis.
2a. Transportation program primarily managed by the Community Health Assistants who assist members with linkage to reliable transportation resources.
3a. Escalation of complex and high-risk membership to Geisinger @ Home to allow for those in the rising risk population to be enrolled in a Care Management program or to be connected with a care team member. Any member discharging from Geisinger Hospitals with a complex risk score, identified as home bound with complex needs, members identified with clinical management issues resulting in increased and/or inappropriate utilization are referred to G@H for ongoing management. Geisinger @ Home provides in home services by a provider and interdisciplinary care team. These services include, but are not limited to checkups, routine testing, wound care, respiratory care, nutritional needs, urgent and specialty care. We will monitor the volume of referrals to G@H and actual enrollment. We will monitor and review overall utilization for this population. 3b. Referral to Behavioral Health Care Management team for members with a psychiatric admission for transition of care with a primary mental health or substance use disorder diagnosis. 3c. Adherence to antipsychotic medications for Individuals with Schizophrenia (SAA HEDIS Measure) – GHP pharmacy sends letters to members 18 years of age and older with Schizophrenia or Schizoaffective disorder who were dispensed an antipsychotic medication and have a PDC (proportion of days covered) less than 80% to notify them that they are non-adherent to one or more antipsychotic medication(s) and remind them to refill if appropriate.
4a. Pilot and provide and Interactive Voice Response (IVR) program for moderate to low-risk members following hospital discharge. These are the members who do not meet the criteria for complex care management or Geisinger @ Home intervention. GHP will monitor the volume identified for the program, volume engaged, and volume of triggers/alerts for CM follow up.
5a. Alerts to the Behavioral Health Care Management team for those members enrolled who are identified with an initial Substance Use disorder diagnosis.

Summary of Interventions
5b. Referral to Addiction Coordinators on the Behavioral Health Care Management team for members identified for SUD dx (HEDIS IET).
PH-MCO – HPP – PIP 1: Preventing Inappropriate Use or Overuse of Opioids
1. Peer to peer prescribing education
2. Education for members self-identified as high risk for opioid use/misuse on the Opioid Risk Tool (ORT): a brief, self-reporting screening tool designed to assess risk for opioid abuse for adult individuals prescribed opioids for treatment of chronic pain, embedded in the Health Assessment
3. Pharmacy Medication Therapy Management (MTM), a program designed to help members with specific medical needs get pharmacist attention/education to help take their medications safely and effectively at point of sale, for members ages 18 years and older
4. Face to face/virtual counseling and education for Medication Assisted Therapy (MAT) for member 18 years and older with OUD diagnosis
5. Case management to assist members PCP or COE follow-up visit within 7 days of opioid related ED visit
PH-MCO – HPP – PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
1. Case management to assist adult members with PCP/Specialist follow-up visit within 7 days of inpatient hospital discharge.
2. Provider notification of members with inpatient discharge at Patient Centered Medical Home (PCMH) practice groups for PCP/Specialist follow-up visits.
3. Care coordination for members that self-identify with alcohol or substance use dependence.
4. Medication Therapy Management (MTM) Targeted Intervention Protocols (TIPs) for members prescribed antipsychotic medication. The MTM program utilizes real-time pharmacy claims data to inform the community pharmacist of a member's non-adherence to their antipsychotic medication in the form of a TIP so the community pharmacy can counsel the member at the point of sale.
5. Embedded case manager at Broad Street Ministry (BSM) to complete ICPs to reduce ED visits, inpatient admissions, and readmissions
PH-MCO – HWC – PIP 1: Preventing Inappropriate Use or Overuse of Opioids
1. Lancaster EMS community paramedicine post-overdose follow up to provide education regarding available treatment options, provide appropriate referrals to treatment and support the member in accessing treatment.
2**.** Increase the number of first responder ambulance companies who provide SBIRT and/or post overdose follow up to members who experience an overdose but do not consent to treatment in the emergency department.
Revised 2. Increase the number of members who access treatment for SUD post overdose referred to HWC behavioral health Case Management by an EMS agency after EMS response to a substance use related emergency**.**
3. Case Management follow-up for members identified by Admission, Discharge and Transfer data for ED utilization related to substance abuse to ensure that the member received appropriate referral to treatment and initiated treatment.
4. Members who are identified by Utilization Management (UM) during clinical review as having an OUD will be referred to Case Management (CM) for support and intervention to address the member's underlying OUD diagnosis.
5. HWC is working with a BH-MCO partner (Perform Care) to administer a provider survey among the top 5 Primary Care Provider (PCP) offices in the shared service area to identify barriers that may prevent PCPs from screening patients for SUD and/or prescribing MAT. Based on responses received, HWC and PerformCare will provide the PCP with interventions to reducing the barrier.
6. Deploy training and information to providers on SBIRT by HWC Clinical Addictions Specialists.

Summary of Interventions
7. Through HWC's virtually integrated care collaboration networks, HWC will implement behavioral health and addiction specific sub-committees to support health systems in developing tools and workflows to support identifying, engaging and supporting members in obtaining OUD treatment throughout the continuum of care.
PH-MCO – HWC – PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
1. The HWC Delivery Systems Transformation Team will educate and provide data to HWC's high volume Primary Care Practices to assist providers in identifying and outreaching to members on their assigned panels who have not had a PCP visit in the past 15 months and will schedule member for appointment. The member's assigned Primary Care Provider practices receive a list, from HWC, of attributed members who HWC does not have a claim for a PCP visit in the past 15 months. The report is provided on a quarterly basis. This intervention is targeted to the entire HWC PA Medicaid member population who is assigned to a high volume provider.
2**.** Increase member education through member newsletter articles, Case Management education, social media, and provider education to patients regarding access to 24 hour/7 day a week Nurseline.
3. Use of Admission, Discharge, Transfer (ADT) data available through Health information exchanges to identify members with recent ED utilization to support members in receiving necessary follow up care. This report is shared with both internal HWC case managers as well as the member's primary care provider.
4. Members identified as having recent ED or inpatient utilization will receive follow up from Case Management within 2 business days of the ED visit or inpatient discharge to educate the member on the need for a follow up appointment.
5. Notify prescribers via provider portal that a patient that they prescribe antipsychotic medications to has become non-adherent to the medication having a proportion of days covered (PDC) of less than 85% which could lead to ED utilization of the SMI population, Inpatient Admissions in the SMI population and Inpatient Readmissions in the SMI population and encourage providers to schedule an appointment with the patient or outreach to the patient to address medication adherence concerns and support the patient in resolving medication adherence concerns.
6. Identify members with co-occurring serious mental illness and substance use disorder for integrated care planning with the BH-MCO and their medical and behavioral health providers to collaboratively develop an integrated care plan to ensure that the member's medical, behavioral health, and social needs are adequately being met through holistic care provided by members of the care team.
7. Supply home delivered meals post-hospital discharge for members who screen positive for food insecurity and have secure housing upon discharge from hospital.
8. Visits to the member home by community paramedics to assess and provide referrals to address SDOH, including mental health and substance abuse, concerns within seven days after an emergency department visit or hospital discharge.
PH-MCO – KF – PIP 1: Preventing Inappropriate Use or Overuse of Opioids
1. Care Managers will outreach and educate the members with risk of continued use of opioids after 15 days (in a 30 day period) or 31 days (in a 62 day period). Outreach will be via phone and/or letter.
2**.** Bright Start maternity team will offer a home visitation program for all African American pregnant women with Opioid Use Disorder.
3**.** Emergency Room overdose follow-up: Rapid Response Outreach Team will make telephonic outreach to members identified through Health Information Exchanges, who have been to the Emergency Department with a diagnosis of overdose to assist with coordination of care and referral to appropriate resources.
4. Keystone First community facing teams will attempt to obtain consent forms from members with opioid use disorder when working with members in the community face to face.
5. Outreach to providers of members that are on both Opioids and Benzodiazepine.
6. Outreach to members newly initiated on buprenorphine to provide education and support to ensure adherence to prescribed regimen.

Summary of Interventions
PH-MCO – KF – PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
1. ED High Utilizer Outreach enhanced with ADT activity automation. Automated activity for outreach is generated for high ED utilizers following an ED visit notification through Health Share Exchange. A Care Connector calls member, assesses needs, provides alternatives to ED, addresses barriers, and assists with making follow up appt. with PCP and/or specialist.
2. Rapid Response team to educate caregivers on appropriate use of Emergency Department and provide information on services available to be used instead of going to the ED.
3. Transitions of Care Pathway High risk Members discharged from Inpatient hospitalization are assigned to a Care Manager to call the member to complete medication reconciliation, provide education regarding condition, medications, and follow up care, and assist with making f/u appt, and ensuring transportation to appt.
4. City Life: Members will be able to schedule a telehealth appointment with a doctor when unable to access their own doctor. Availability of the program will be communicated to members by Care Manager's, Acute Care Transition (ACT) nurses embedded within hospital emergency departments, and the health plan Rapid Response Outreach Team (RROT). Upon completion of appointment, City Life will provide a summary of the telehealth appointment to the member's primary care provider, who will be able to coordinate further follow-up as needed.
5. Diabetes Pathway for members with SPMI. Members with a diagnosis of SPMI and diabetes will be assigned to a Care Manager to assess member's needs and barriers, educate member on condition, medications, PCP visit schedule/screening measures, and assist in resolving barriers. Focus will be on African American population.
PH-MCO – UHC – PIP 1: Preventing Inappropriate Use or Overuse of Opioids
1. Behavioral Health Advocates Behavioral Health Advocates (BHA) outreach to members with an OUD diagnosis in acute care to connect them to MAT providers
2. Warm Handoff to Center of Excellence (COE) BHAs coordinate warm handoffs to Centers of Excellence for members with an OUD related ED visit. A warm handoff is considered a transfer of care between two members of the health care team with the member present. The warm handoff is usually completed face to face but may be completed as a conference call between all the parties if barriers prevent a face-to-face transfer of care (i.e., Covid-19).
3. Optum Pharmacy Retrospective Abused Medication Program (RAMP) This is a provider-targeted program designed to minimize the occurrence of drug abuse, diversion, and inappropriate use in members utilizing high-risk medications. Medication classes include Opioids. Benzodiazepines; Buprenorphine. Provider outreach and education is completed if member is identified to be on a high cumulative daily dose of opioid analgesic and/or overlap of an opioid analgesic and benzodiazepine.
4. ACO/PCMH Pilot on Opioid Performance Indicators Key Performance indicators for opioid prescribing practices will be shared with each ACO/PCMH during JOC committee meetings.
5. Value Based Purchasing Program SUD specific New VBP program was established with Temple University focusing on medication adherence to MAT. This program may expand to additional providers over the course of the PIP.
6. Siloam Program - provides alternative therapy and wellness services to members with HIV, SUD, diabetes, and chronic pain in select Philadelphia zip codes. Program offering yoga, reiki, and wellness counseling, among other alternative therapies.
7. SUD Pregnancy Programs Expansion SUD Substance Use Disorder Maternal Health Homes – SUD Health homes are OB providers that work with women with SUD diagnoses throughout prenatal and into postpartum care to ensure consistent care is available, support is in place, and medications are managed. These supports continue into postpartum timeframe to ensure a more stable and healthy development of family. Pregnant women enrolled in SUD Maternal Health Homes are more likely to be

Summary of Interventions
engaged in MAT and less likely to discontinue treatment early. In 2019, 89% of members enrolled in a Substance Use Disorder Maternal Health Home received MAT, and 50% of those members had 365 days of continuous treatment in 2019. All members enrolled in 2019 had continuous MAT from the date of program enrollment until the end of the calendar year. As a result, this program was expanded in January 2020 and two additional SUD maternal health homes were added.
PH-MCO – UHC – PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
1. Accountable Care Organization Program Expansion Expansion of ACO Program in 2020 to include a larger percentage of the overall member population. Goal of the ACO program is to reduce avoidable ED visits and admits by near real-time data sharing, population management tools, and same day appointments. This is a strategic program to partner with the Practitioner sites whose staff will review discharges daily in UHC's Accountable Care Population Registry and outreach to their recently discharged members to schedule PCP visits within 7 days. This can assist with reducing avoidable emergency department visits, admissions & readmissions.
2. PCMH Program Expansion Expansion of the PCMH Program in 2020 to include a larger percentage of the overall member population. The PCMH program focuses on coordination of care in a community-based model. Goals of the PCMH program are a reduction in preventable ED visits and admits by Providing comprehensive primary care for children, youth, and adult, facilitating partnerships between patients and their personal physician, the patient's family and caregivers, and the community, Promote increased access to care and improved care quality, Incorporate surveys in practices related to gaining information on social determinants of health (SDOH).
3. Verification of Provider Visits (VOPV) Outreach call is completed to Primary Care Provider by WPC team within 7 days of hospital discharge to assure PCP is aware of hospitalization and member has a follow up appointment.
4. DocChat DocChat is an application-based intervention that allows members to text with an Emergency Physician to assist in determining a correct level of care. The target population for the resource is members who have two or more Emergency room visits specifically for low acuity non-emergent diagnoses receive mailer, email, or text message to introduce the program, but it is accessible to all members.
5. Urgent Care Mailer Expansion Members who utilize the ED three or more times in 6 months in Med Express counties currently receive a mailer with information on Med Express locations available in their area. This program will be expanded and members outside of those counties will receive a mailer with education appropriate for ER utilization and a list of in-network urgent care centers in their area. Process for mailer creation and approval took longer than expected. Mailings began Q2 2021. No mailings completed in 2020.
6. Lancaster EMS (LEMSA) Partnership with LEMSA to provide Paramedicine services in Lancaster County. In home paramedicine will be provided to members coming out of an inpatient stay who are high risk for readmission. These members may have diagnoses including but not limited to CHF, COPD, Sepsis, DM, other chronic dx. Visits include medication reconciliation, follow up care coordination, medical services as needed, and general safety and wellness education.
7. AdhereHealth™ SPC/SPD Project AdhereHealth™ vendor is being contracted to complete outreach to members with cardiovascular disease and/or diabetes who are noncompliant with their Statin medication. AdhereHeatlh™ performs telephonic outreach to the member to identify and address barriers related to medication adherence and provide member education when feasible. Program launched in September 2020 for SPC. SPD outreach began in October 2020.
8. Pennsylvania Pharmacist Care Network (PPCN) Program

Summary of Interventions
Members with COPD and/or Diabetes receive education on their disease state and medication from a PPCN pharmacist. In person education is provided to the member where they currently fill their prescriptions. Program was planned to launch in Q4 2020 but did not launch until Q2 2021 due to delays in contracting process.
9. ICP Joint Operating Committee (JOC) Meetings JOC Meetings were started with the BHMCOs in Q4 2020. The JOC meetings are in addition to the clinical rounds that currently take place with the BHMCOs. These JOC meetings will include BHMCO medical directors and focus on ways to improve integration of care and coordination of care with BHMCOs. In Q4 2020 the WPC team began to share gap in care lists for the SAA measure with the BHMCOs to allow for better collaboration on these members and referral to the ICP program if needed. This modification was made due to ITM 10 not being implemented as planned.
10. AdhereHealth™ SAA Project AdhereHealth™ vendor is being contracted to complete outreach to the SAA measure population who are noncompliant with their antipsychotic medication. AdhereHeatlh™ performs telephonic outreach to the member and the prescriber to identify and address barriers related to medication adherence and provide member education when feasible. This intervention did not launch in 2020 as planned due to barriers encountered in the contracting process. The vendor declined to move forward with outreach. As a result, sharing of gap in care lists for the SAA measure with the BHMCOs was implemented under ITM 9 BHMCO JOC meetings to further address this barrier.
11. Disparities Score Card UHC has developed a disparity score card to assure that providers are aware of the disparities that currently exist in the African American member population. The Clinical Practice Consultants (CPCs) review this score card with individual. The score card includes the individual practice rates and benchmarking comparison to peers. This not only educates practices on their individual rates for the targeted measures, but also provides a platform for discussion and education on how to improve healthcare disparities at the practice level.
12. African American Blood Pressure and Diabetes Pilot Project African American members with gaps in care for poorly controlled diabetes and high blood pressure, which puts them at higher risk for inpatient admission, readmission, and ED utilization. Members receive a culturally appropriate mailer followed by a live telephonic outreach call by a QM team member to support screening education, appointment scheduling, Bio-IQ in-home test kit, and a home visit (where applicable). When calling members, we review all risk factors and program incentives, and members may qualify for 2020 reward program for completing a HbA1c test. A resource listing of program and services was created and shared during live calls with members. Members engaged will be monitored over 90 days and claims reviewed to determine if additional outreach is needed.
PH-MCO – UPMC – PIP 1: Preventing Inappropriate Use or Overuse of Opioids
1. Enhanced telephonic provider/prescriber outreach conducted by Health Plan (HP) pharmacist for members who received prescription opioids at high dosage MME ≥90 for ≥90 consecutive days and are not seeing a pain management provider. The enhancement to the telephonic pharmacist outreach includes new stratification that lowered the MME threshold from MME ≥120 to MME ≥90. Outreach aims to assist providers/prescribers with opioid tapering recommendations, coordinate care through pain management services, and decrease the use of opioids at high dosage.
2. Institute telephonic provider/prescriber outreach conducted by HP pharmacist for members who received high risk medication combinations.

Summary of Interventions
Telephonic pharmacist outreach increases provider/prescriber awareness, provides opioid tapering recommendations, and decrease the concurrent use of opioids and benzodiazepines.
3. Implement telephonic provider/prescriber outreach conducted by HP pharmacist for members who received prescription opioids at high dose MME ≥90 for ≥90 days with ≥4 prescribers and ≥3 pharmacies. Telephonic pharmacist outreach increases provider/prescriber awareness, provides opioid tapering recommendations, coordinates care through pain management services, and improves the use of opioids from multiple prescribers and multiple pharmacies. Use of opioids from multiple prescribers and multiple pharmacies is a lower performing sub-measure of the PI that is subject to variability throughout the MY requiring continuous intervention.
4. Implement telephonic outreach conducted by HP pharmacist to members for MAT nonadherence. Telephonic outreach to members provides members with MAT adherence strategies, identifies and resolves adherence barriers, coordinates care activities, and positively impacts individuals with OUD who receive MAT and pharmacotherapy.
5. Expand the REDO program to one additional high-volume hospital emergency department. Current REDO program includes one high volume hospital ED. REDO intervention includes admit to OUD/SUD treatment, appointment with MAT provider, appointment with PCP, and provides member with recovery information. Expansion determination was based on the success of the program to date and the program's member reach rate. Internal data was used to determine the expansion hospital identified as the next highest-volume ED with the highest OUD/SUD overdose diagnoses. Expansion plans include this one hospital ED. Expansion aims to improve the percent of individuals with OUD who receive MAT, the percent of adults 18 years and older with pharmacotherapy for OUD, members who receive follow-up treatment within 7 days after ED visit for OUD.
6. Incorporate SDOH supports and resources in REDO program outreach. In addition to REDO's immediate outreach to members after an ED discharge, members are provided a SDOH needs assessment. SDOH assessments identify SDOH barriers which prompt REDO intervention to provide SDOH support and resources. Assessments help improve member health outcomes and increase the percent of individuals with OUD who receive MAT, pharmacotherapy continuous treatment, and members who receive follow-up treatment within 7 days after ED visit for OUD.
PH-MCO – UPMC – PIP 2: Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits
1. Develop new member wellness plans through the Community Team program to assist members in managing their health. Wellness plans serve as a comprehensive guide to help members manage their health by identifying warning signs, developing coping strategies, and establishing a support system and care providers. Wellness plans aim to reduce ED visits, inpatient utilization, and readmissions.
2. Enhance Rapid ICP program member stratification targeting outreach to Medicaid members in the SPMI population discharged from a high-volume ED. New member stratification parameters: Tier 3 with three or more ED visits in the past 12 months. Enhancements aim to reduce ED visits, inpatient utilization, and readmissions for members in the targeted SPMI population.

Summary of Interventions
Outreach includes Connection to BH treatment, coordination with BH MCO, and SDOH assessment and referrals.
3. Expand the REDO program to one additional high-volume hospital emergency department. Current REDO program includes one high volume hospital ED. Expansion determination is based on both the success of the program to date and internal data that identified the expansion hospital as the next highest-volume ED with the highest SUD overdose diagnoses. Expansion will improve the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment and help reduce ED visits.
4. Incorporate SDOH supports and resources in REDO program outreach. In addition to REDO's immediate outreach to members after an ED discharge, members are provided a SDOH needs assessment. SDOH assessments identify SDOH barriers which prompt REDO intervention to provide SDOH support and resources. Assessments help improve member health outcomes and help reduce ED visits, inpatient utilization, and readmissions.
5. Institute a new data feedback loop daily between supervisors and care managers to increase the number of Integrated Care Plans completed by the HP care managers. Data feedback loop enhancements include supervisors providing care managers with internal status reports/data on completed ICPs. Enhancements will improve member health outcomes for Medicaid members with SPMI including initiation and engagement of alcohol and drug treatment, antipsychotic medication adherence, ED visits, inpatient utilization, and readmissions.
6. Develop and utilize new e-consent to improve member coordination of care between PH MCO and BH MCO. Total consents are a combination of consents obtained from the Health Plan or a BH MCO. Coordination between the PH MCO and BH MCOs is a contractual part of the ICP process. E-consents aim to improve care coordination for the Medicaid member with SPMI and positively impact initiation and engagement of alcohol and drug treatment, antipsychotic medication adherence, ED visits, inpatient utilization, and readmissions.

CHIP Performance Improvement Project Interventions

As referenced in **Section I: Performance Improvement Projects, Table A2** lists all of the interventions outlined in the CHIP-MCOs' most recent PIP submissions for the review year. The interventions are taken verbatim from the MCOs' PIP reports.

Table A2: CHIP-MCO PIP Interventions

Summary of Interventions
CHIP-MCO – ABH – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Primary care provider (PCP) referral to Pediatric Dentist to increase dental compliance.
2. Offices set aside a day or half day for Aetna CHIP members for appointment scheduling.
3. ABH partners with dental providers to engage members non-adherent for annual dental visit (ADV).
4. Telephonic outreach by a licensed and credentialed Public Health Dental Hygienist Practitioners (PHDHPs) with members non-adherent for ADV are provided with dental education (oral hygiene instructions) and appointment scheduling.
5. Members non-adherent for ADV are outreached via text or automated calls to educate members and connect for appointment scheduling.
6. Sealant mailer explaining what a sealant is, its importance, and its procedure is sent out to members that are non-adherent for Sealant Receipt on Permanent First Molars (SFM).

Summary of Interventions
7. Dental and Medical QPLs outreach providers in person, telephonically or virtually to review Gaps in Care Reports (HEDIS and PAPM rates), Provider website and documents, Tobacco Cessation Certification information.
8. Webinar reviews dental gaps in care reports, teledentistry, QPL program, HEDIS and PAPM measure, provider website, Tobacco Cessation Certification.
9. Webinar reviews dental gaps in care report, the impact of Social Determinates of Health on oral health, strategies to improve maternal oral health, tactics to reduce dental disease in children, solutions for oral care health delivery.
CHIP-MCO – ABH – PIP 2: Improving Blood Lead Screening Rates in Children
1. Quality Practice Liaisons (QPLs) provider outreach. Quality Practice Liaisons (QPLs) will discuss Gaps In Care Reports and Strategies for Improvement through onsite visits to provider offices and virtual meetings with providers.
2. Provider Pay for Quality (P4Q) program. This program incentivizes providers to order lead testing for all members and ensure that they are completed. Providers must reach a benchmark of the NCQA 75% (Tier 1) or 90th (Tier 2) percentile to earn the incentive.
3. Outreach calls to members who are non-adherent for a lead screening.
4. Outreach to members with elevated lead levels through Care Management (CM).
CHIP-MCO – CBC – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Best Next Action: When a member's parent/guardian places a call to member services, the representative is notified whether an open gap exists for the member and the representative reminds the caller to have the screening performed.
2. Email campaign to members with messaging on the importance of dental care.
3. Dental van event.
3. Share HEDIS scoreboard data with CHIP high volume providers in a value-based relationship on either monthly or quarterly clinical quality meetings.
CHIP-MCO – CBC – PIP 2: Improving Blood Lead Screening Rates in Children
1. Best Next Action: When a member's parent/guardian places a call to member services, the representative is notified whether an open gap exists for the member and the representative reminds the caller to have the screening performed.
2. Email Campaigns to members with messaging on preventive care and options for seeking care.
3. Share HEDIS scoreboard data with CHIP high volume provider groups in a value-based relationship on either monthly or quarterly clinical quality meetings.
4. Track Capital's improvements to acquire BLL data for improved PIP reporting.
CHIP-MCO – GEI – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Public Health Dental Hygiene Practitioner telephonic outreach to complete member oral hygiene education.
2. Public Health Dental Hygiene Practitioner telephonic outreach to schedule and establish dental homes for members.
CHIP-MCO – GEI – PIP 2: Improving Blood Lead Screening Rates in Children
1. Education to providers on appropriate timeframe for completing lead lab draw screening.
2. CHIP Member Lead Incentive for completing lead lab draw.
3. Member letters sent to members newly identified with a BLL > 3.5. Letter includes CDC recommendations, signs/symptoms of lead toxicity, and encourages members to contact PCP for repeat blood testing.
4. Special Needs Unit Coordinator contacts members who have had a blood lead level > 5 and refers to Environmental Lead Investigation (ELI). *Two tests ≥ 5.
CHIP-MCO – HPP – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Member Incentive Program: members ages 2-19 years of age that complete a dental visit scheduled via outreach & scheduling vendor receive a gift card.
2. Member Outreach Program: outreach to members ages 2-14 years of age overdue for an annual dental visit to schedule a dental visit.
3. Dental Rewards Program: HPP members ages 0-14 years that complete a dental exam are eligible for a $20 prepaid debit card through the HPP Rewards program.
4. Dental Provider Care Gap Outreach to complete dental visits: Dental providers are given reports of patients in their practice who have not had a dental visit in the past 12 months for outreach and scheduling.

Summary of Interventions
5. Community Dental Events: partner with the St. Christopher Dental Van to hold community dental events at provider sites during which members can complete a dental visit (ages 10 – 14 years) and a well visit with their medical provider.
6. Care Management for High-Risk members with Developmental Delay. Care management will assist with coordination of dental visit appointment during telephonic outreach for members who are due/overdue for a dental exam.
7. Educational workshops: Partner with local Head Starts to provide oral health educational workshops on the importance of fluoride varnish and oral hygiene
8. Topical Fluoride Varnish (TFV) Care Gap Report: Dental providers are given reports of patients in their practice who have not had a dental visit in the past 12 months for outreach and scheduling. Support is provided throughout the year, including a progress report to help monitor and track their progress on closing members care gaps
9. Dental Health Events: Partner with network providers to hold community dental events at primary care provider sites during which members (ages 2-12) receive education on topical fluoride varnish and then receive fluoride varnish application
CHIP-MCO – HPP – PIP 2: Improving Blood Lead Screening Rates in Children
1. In-home lead screenings: outreach calls to parents/guardians of members due for a lead screening and an in-home lead visit is offered, in which a technician from our vendor partner will visit the member's home to complete the screening.
2. Member Rewards Program: Members ages < 24 months that complete a capillary or venous blood lead test during the measurement year are eligible to redeem 200 reward points to be used on the HPP rewards member portal.
3. Provider Report Cards to targeted Tax Identification Number (TINs) that are low performing with lead screening.
4. Automated calls/texts and live outreach calls to members with blood lead level between 3.5-4.9.
5. Care management for members with > 5 blood lead level.
6. Automated calls to members overdue with lead screening.
7. Provider performance sheets for targeted providers (top 10 sites) with members overdue for lead screening.
CHIP-MCO – HHK – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Outreach activities to members who are identified in the eligible population that did not complete a dental visit in the prior 12 months to help them find a provider and to help them schedule in advance.
2. United Concordia will provide Member Opportunity reporting to CHIP providers notifying them of members who were previously seen by the provider but have not been seen for an annual dental visit in the last 9 months.
3. Engagement of members with no attribution (no well visit claims within the last 18 months) Member Engagement Guide (MEG) outreach activities to members who are identified in the eligible population that did not complete a dental visit in the prior 12 months to help them find a provider and to help them schedule in advance.
4. Mobile Dental Unit – A 7 day tour from Pittsburgh to Allentown servicing CHIP members in need of an annual dental visit.
CHIP-MCO – HHK – PIP 2: Improving Blood Lead Screening Rates in Children
1. Clinical Transformation Consultants (CTCs) perform outreach to providers to identify a solution for concerns to complete lead blood screening. Provide education to providers on the importance of lead blood testing vs. risk assessment completion.
2. Member Engagement Guides (MEGs) will outreach to members under 2 years of age or are turning 2 in the measurement year with a lead screening gap.
3. Engagement of members with no attribution (no well visit claims within the last 18 months).
CHIP-MCO – IBC – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Email or text messages sent to parents/guardian of members without a dental visit at least once in the past nine month encouraging them to schedule dental visit.
2. Member Opportunity Report mailed to providers includes a gap in care report with a list of members with a dental visit claim at that office in the past 4 years but no dental visits in the last 9 months.
3. Send notices to dental providers advising to perform and submit claims for these services.
4. Email and text messages sent to parent encouraging them to ensure children receive dental sealants.
CHIP-MCO – IBC – PIP 2: Improving Blood Lead Screening Rates in Children

Summary of Interventions
1 The plan implemented its New Provider Lead Testing in Provider's Office Program in 2022. It consisted of: • Provider practices and staff received in-office training from collaborating vendor, Labcorp to administer lead test during office visit using the filter paper method. This was the first time the plan has done this type of provider intervention. • The plan implemented two additional new options for lead test during 2022. (1) Lead testing at a LabCorp Service Center and (2) Lead testing Labcorp at Walgreens location. • Plan mailed gap list of children needing lead test to provider practices, information regarding in-office training with collaborating vendor, Labcorp; and options for lead testing. • Plan informed caregivers that children can now receive lead testing in their provider's office via member mailings, newsletter articles, email, and text reminders.
2. Health Coaches, Population Health Specialists, and other Care Management team tracked lead retests for members identified with elevated BLL until test results were under the recommended reference range of 3.5 ug/dL. • Plan utilized outreach calls to providers requesting children identified with elevated BLL are retested. • Plan identified elevated BLL using lead lab claims, lead lab reports from Labcorp, provider faxed-back lead lab results, and health equity analyses for its provider intervention.
3. Assessment of compliance with 3-month re-test guidelines stratified by high and low-risk zip codes and race/ethnicity among kids first identified for elevated BLL at ≤27 months: • Information reported in our 2022 Interim Year 1 Report is a 2022 intervention was developed to analyze elevated BLL for lead testing in high and low risk zip codes. Intervention(s) were developed and implemented in 2023 to capture the most vulnerable members from the 2022 analysis and will be reflected in our Final Year 2, 8/15/2024 Submission Report to IPRO. • The plan reviewed indicators of disparities in follow up for elevated BLLs across high vs low risk zip codes for elevated BBLs, and race and ethnic groups. • The plan defined high risk zip codes through two methods (1) 5-year claims look back of BLL results across the Southeastern PA 5 county region including all business cuts (CHIP, Commercial, etc.), (2) publicly available data on social determinant of health risks through the Social Barrier Index (SBI). Please refer to the Health Equity Risk Social Barrier Index in the Report Section on Pages 30-31 for more information about SBI. • Plan Health Coaches, Population Health Specialists, and other Care Coordination team will track children with elevated BLL for appropriate follow up care. • Once the Plan determines the specific populations at risk for disproportionate gaps in follow up testing (by residence in high-risk zip codes and/or race/ethnicity), the plan will develop additional targeted initiative(s) to address identified inequities in timely follow-up testing for children with elevated BLLs, as appropriate.
4. Member Email or Text Message Reminder: The plan sent gap email or text reminders to caregivers of children 0-30 months to schedule and receive recommended well visits: • Low Performing Provider (LPP) Report: The Plan sent performance reports to LPP providers. Population Health Specialists worked directly with identified LPP providers to improve well visit compliance rates among children 0-30 months.
CHIP-MCO – UHC – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Dental Hygienist telephonic outreach program. Dental hygiene and nutritional education is provided with the goal of improving member awareness of the importance of dental preventative services. The dental hygienist will attempt to link the member with a dental home and make a dental appointment to increase utilization. Successful outreach to members will close the annual dental gap in care utilizing the code D1310.
2. Sealant Summit and Provider Incentive. Annual sealant summit with key providers highlighting dental sealant utilization. Best practices are discussed. A provider incentive of $5.00 per dental provider per sealant for members 6-16 years of age is offered during the month of October for an increase in dental sealant application from the previous year. Providers receive fax communication and education by clinical practice consults (CPCs) on this incentive
3. Federally Qualified Health Center (FQHC) Dental Letter. Letter includes information on how good oral care and healthy diet leads to a lifetime of strong healthy teeth. Education includes an explanation of dental benefits; a routine dental visits every 6 months.
4. Clinical Practice Consultant Outreach. Provide on-going education and gap in care list to providers as well as resources including complete list of in-network dental providers. Encourage and support practices to look at barriers

Summary of Interventions
and begin putting systems in place to focus on importance of screening compliance, preventive health visits, and education on dental health.
CHIP-MCO – UHC – PIP 2: Improving Blood Lead Screening Rates in Children
1. Omni Channel Member Outreach. Outreach will enable three different methods/channels of communication with members: email, text, and IVR calling. It will serve as a reminder to get lead screening and include education
2. Quality Team Member Outreach. Live telephonic outreach focusing on members 6-17 months of age to proactively provide education and assure adequate opportunity is given for parent/guardian to obtain a lead screening for child by age 2.
3. Quest Pilot Program. Quest Health Connect is a vendor pilot program targeting UHC members 6-18 months of age for lead blood screening. Eligible members will be mailed an introduction letter from the vendor to encourage scheduling and provide website and phone number to schedule appointment. Quest Health Connect will also outreach to the parent/guardian of eligible members to assist with scheduling a lead blood test at a Quest Patient Service Center.
4. Focused Education on low performing providers. Clinical Practice Consultants (CPCs) will provide focused outreach to the 7 ACO/PCMH providers groups with members aged 0-2 years with a lead compliance rate at or below 60% on the availability and benefits of Medtox and Kirby Point of Care (POC) testing that is available for providers to complete Lead Screenings for members while they are in office as well as structured data, and education on current lead screening requirements.
5. Clinical Practice Consultant Outreach. The CPCs provide on-going education and resources to providers (both high-volume and overall providers) with children aged 0-2 years by providing the offices with their gap in care list. CPCs encourage and support practices to look at barriers and begin putting systems in place to focus on importance of screening compliance, importance of preventive health visits, education on disease states and lab screenings.
6. Let's Get Checked Program. An in-home lead testing program that auto deploys test kits and letter to all non-compliant members ages 6-18 months. Testing kit includes all the necessary supplies to perform a capillary blood test. Members receive an announcement letter that communicating a test kit is being provided at no cost. The test kit provides testing information such as the option to complete testing in-home or take the test kit to their pediatrician for completion.
CHIP-MCO – UPMC – PIP 1: Improving Access to Pediatric Preventive Dental Care
1. Hire a PHDHP to educate members on oral hygiene and preventive dental care.
2. Utilize Clark Resources vendor to assist the member with scheduling a dental appointment.
3. Educate physical health providers on topical fluoride varnish application.
CHIP-MCO – UPMC – PIP 2: Improving Blood Lead Screening Rates in Children
1. Enhance targeted marketing outreach to members living in high lead areas.
2. Refined telephonic outreach to members with an initial elevated capillary blood lead screen to encourage the completion of a second confirmatory venous blood lead screening.
3. Enhance case management follow-up intervention protocols for members with a confirmed elevated blood lead level.

BH Performance Improvement Project Interventions

Table A3: BH-MCO PIP Interventions

Summary of Interventions
Carelon
Intervention #1a: Carelon will increase provider understanding of the clinical application of ASAM Criteria during continued stay reviews as the standard of care for treating members with a Substance Use Disorder by providing education to the network of contracted SUD providers. **Intervention #1b**: Carelon will support provider application of the ASAM criteria by conducting annual medical record abstraction reviews with five (5) pilot SUD treatment providers to determine fidelity to the ASAM criteria. The record abstractions will be completed by a trained team of clinicians

Summary of Interventions
Intervention #1c: Carelon will conduct SUD specific high-utilizer clinical rounds every two weeks for members who have had three (3) or more admissions to the same or higher level of care within a rolling 60 day period to ensure this high-risk population is receiving the most appropriate individualized treatment and appropriate education and referrals (medical, social determinates, racial/ethnic disparities) for their conditions. **Intervention #1d:** Carelon will provide technical assistance to providers through conducting programmatic readiness reviews for application of the ASAM criteria. **Intervention #1e-1:** Carelon will request and host presentations from all COEs in the Carelon Network. These initial meetings will be structured for the COEs to review their Service Descriptions for providing COE services. **Intervention #1e-2:** Carelon will complete a COE Program expectations guide to accompany the DHS COE program guide in order to help shape the service delivery of the COEs. **Intervention #1e-3:** Carelon will conduct training on the COE Program expectations/DHS COE expectations for the COE providers in their network. **Intervention #1e-4:** Carelon will create a monthly provider survey on COE expectations to gather data that will help shape COE strategic plans. **Intervention #1e-5:** Carelon Provider Quality Managers will create strategic plans for all their SUD COEs
Intervention #2a: Carelon will conduct an annual provider webinar, facilitated by the Carelon medical director, on the topic of pharmacotherapy in combination with psychosocial treatment, as the standard of care for treating opioid and alcohol use disorders. **Intervention #2b**Carelon will implement a value based payment arrangement to provide an opportunity for providers to receive performance incentives to increase utilization of pharmacotherapy concurrent with counseling for substance use disorder treatment, when clinically indicated. Carelon and Primary Contractors will identify providers to agree to contract for the MAT VBP incentive arrangement. **Intervention #2c**: Quarterly, Carelon will distribute member education on treatment choices available to them on their treatment journey specifically related to substance use disorder through one or several of the following mediums: educational forums for members, publishing education on the member's section of the Carelon website, distributing education to members via the Carelon Family Advisory Council.
Population Health Prevention Strategy **Intervention #3a**: Carelon will facilitate an annual Community Listening Forum (Faces and Voices; SAMHSA, 2017), with a primary objective to eliminate the effects of stigma in the community by providing the community with stories of lived-experience and resiliency of those in recovery from substance use disorders. **Intervention #3b**Carelon will develop and launch an educational anti-stigma campaign. Materials to accompany the Community Listening Forum and other educational forums hosted by Carelon and/or Primary Contractors: **Intervention #3c**: Carelon will offer community trainings in Mental Health First Aid (MHFA) biannually to increase public awareness of identification of mental health and substance use disorders and reduce stigma. **Intervention #3d (formerly #1e):** Carelon will develop a speaker's bureau to offer quarterly training for SUD providers on a variety of SUD Recovery topics. **Intervention #3e:** Carelon and its County partners will hold community trainings on Narcan administration and use of Deterra Pouches to increase public awareness of life-saving measures for overdose events and reduce stigma.
Sub-population Health Prevention Strategy **Intervention #4a:** Carelon will facilitate several Community Listening Forums with Faith Based Organizations, with a primary objective to determine intervention strategies specific to the Black membership which can be piloted in those organizations
Intervention #4b: Carelon will offer community trainings in Mental Health First Aid (MHFA) for Faith Based Organizations identified in areas of Black health disparity to increase public awareness of identification of mental health and substance use disorders and reduce stigma. **Intervention #4c:** Carelon and its County partners will hold community trainings on Narcan administration and use of Deterra Pouches in communities identified in areas of Black health disparity to increase awareness of life-saving measures for overdose events and reduce stigma.
CBH

Summary of Interventions
Intervention #1.1: Identify Clinical best practices for initiation of Black, non-Hispanic members with OUD in treatment by training providers on QI methodology and tools while offering ongoing opportunities for provider collaboration in a joint QI Learning Collaborative (QILC) for Outpatient Substance Use providers to identify and implement interventions using a PDSA cycle framework beginning January 1, 2021, to improve initiation rates. PDSA Cycles were completed in Q2 and Q4 2021 for QILC intervention improvement opportunities. This work included addressing the barriers to ongoing provider participation experienced as a decline in the rate of eligible providers attending forum sessions and completing routine reporting. These are included in part 2 of Section 5, below. Barriers were understood from feedback collected in regular meeting review surveys and during individualized provider coaching meetings. Additional barrier and driver analysis completed in Q3 2022. See Appendix G Modifications include: 1) Creation of a Change Concepts and Measures Package document to support provider selection of change concepts to implement from proven initiation-increasing ideas. This package also clearly defined the method of calculating each measure for reporting and the schedule for reporting. 2) Coaching enhancements. 10 CBH staff who have the CPHQ credential were supported with additional training and monthly plans for use during forum break-out sessions to structure provider interactions and development of innovative change concepts for collaborative testing within tracks. Coaches participated in individual meetings with providers and in the review of monthly reports to provide timely feedback. 3) Standardized review matrix developed to assess providers submitted reports and ensure consistency across measures 4) Adjustment of reporting timeline and frequency of PDSA submissions, beginning Jan. 2022.
Intervention #1.2: Increase community awareness of treatment needs and resources by educating community partners in first quarter of 2022, including faith-based organizations, in areas with a high rate of Black, non-Hispanic members with OUD to increase initiation rates. The target audience for this event is community leaders. However, all Philadelphia County community members will be welcomed to the event. A specific population of community members will be selected by identifying zip code areas where treatment rate is low for Black, non-Hispanic members with OUD and will receive a targeted invitation. A virtual or in-person meeting will be held with the Chief Medical Officer from DBHIDS as an expert speaker with PowerPoint, panel of community members with expertise in the Black, non-Hispanic population and treating OUD, and member services director to share information on how to access treatment. As the planning for this intervention takes shape, the use of virtual vs in-person event opportunities will continue to be assessed to ensure inclusion of attendees. A weblink will be shared for printable toolkit including a one-pager on OUD treatment and an access to treatment guide with list of providers. Implementation of this intervention was delayed due to data availability and analysis to identify the zip code areas of focus. The event occurred in late Q1 2022, followed by posting of the web materials as described above. Additional interventions are being developed to address this barrier.
Intervention #1.3: Intervention 1.3 To Increase community awareness of treatment needs and resources CBH held a workshop at the Faith and Spiritual Affairs Conferences in Philadelphia in April of 2023. CBH focused on creating partnerships opportunities for faith-based organizations and SUD treatment providers by participating in the annual DBHIDS Faith & Spiritual Affairs Conference. The Chief Medical Officer from DBHIDS served as an expert speaker for this in-person event (no virtual component) with a PowerPoint presentation used to share educational material on the Opioid crisis, MAT OUD, and treatment utilization disparities with regional faith leaders and provider staff. The session included an interactive component, with attendees working in small groups to plan local efforts to meet community needs in reducing stigma and encouraging the use of behavioral health supports, including MAT. Conference attendees shared their perception of the Opioid crisis and MAT OUD before and following the education session.
Intervention #1.4: The QILC Spread is an extension of the QILC that was implemented previously in order to improve utilization, sustainability, and spread of best practices for initiation of OUD treatment for Black, non-Hispanic members, as identified through the QILC Spread Intervention for Outpatient Substance Use. Provide an on-demand training resource for providers on QI methodology and tools, while offering ongoing opportunities for provider coaching and individualized support.

Summary of Interventions
Intervention #2.1: Identify Clinical best practices for engagement of Black, non-Hispanic members with OUD in treatment by training providers on QI methodology and tools while offering ongoing opportunities for provider collaboration in a joint QI Collaborative for Outpatient Substance Use providers to identify and implement interventions using a PDSA cycle framework beginning January 1, 2021, to improve engagement rates. PDSA Cycles were completed in Q2 and Q4 2021 for QILC intervention improvement opportunities. This work included addressing the barriers to ongoing provider participation experienced as a decline in the rate of eligible providers attending forum sessions and completing routine reporting. These are included in part 2 of Section 5, below. Barriers were understood from feedback collected in regular meeting review surveys and during individualized provider coaching meetings. Additional barrier and driver analysis completed in Q3 2022. See Appendix G. Modifications include: 1) Creation of a Change Concepts and Measures Package document to support provider selection of change concepts to implement from proven engagement-increasing ideas. This package also clearly defined the method of calculating each measure for reporting and the schedule for reporting. 2) Coaching enhancements, standardized review, and reporting timeline adjustments as described for Barrier 1.1 above. Additional interventions are being developed to address this barrier.
Intervention #2.2: Improve utilization, sustainability, and spread of best practices for engagement in OUD treatment for Black, non-Hispanic members, as identified through QILC Spread Intervention for Outpatient Substance Use. Provide an on-demand training resource for providers on QI methodology and tools, while offering ongoing opportunities for provider coaching and individualized support. To be implemented in Q3 2023
Intervention #3.1: Increase provider implementation of best practices by developing, educating, and monitoring Clinical Practice Guidelines for AUD by January 2021 to increase engagement rates. Conduct an educational session via zoom with expert speaker on use of MAT for AUD, use and implementation of AUD Clinical Practice Guidelines, and access to SUD treatment. Share weblink of printable toolkit of AUD Clinical Practice Guidelines, one-pager AUD and MAT treatment, and AUD Access to Treatment with provider list. Assess use of toolkit by attendees and gains of AUD MAT knowledge via an online feedback survey. Multiple efforts were conducted to assess and address barriers to improvement with this intervention and achievement of CO #3 and #9. Shortly following the webinar in Q1 2021, the PIP planning committee met to understand the failure to engage PH provider participants and consider options for remedy. The group determined that CBH lacks strong channels of communication with PH provider information and training mechanisms. One available mechanism is the quarterly CBH Pharmacy Forum, and arrangements were made to re-share the presentation and web links for the toolkit in Q4 2021. A literature review was conducted to explore options for a member-facing intervention with no actionable interventions identified. The PIP planning group completed a prioritization matrix re-considering potential interventions from the driver diagram. Use of data to identify AUD-MAT provider champions and engage their collective expertise to identify best practices and educational materials was selected for development. See Appendix G. Additional interventions are being developed to address this barrier.
Intervention #3.2: Increase network understanding of barriers to AUD MAT adoption and current frontline efforts to address improvement through engagement of AUD Champions. The group will develop and deliver a virtual Best Practices guide and 3-part webinar series to an audience of CBH SUD treatment provider staff, and other interested stakeholders to begin by 3/31/2023. All materials and event recordings will be available via the CBH website. This model of peer-provider involvement in developing and delivering Best Practices is expected to increase provider use of effective screening and comprehensive treatment for AUD and to increase system knowledge on available resources and forms of MAT for AUD.

Summary of Interventions
Intervention #4.1: Support/incentivize warm hand-offs through development of provider performance standards and pay for performance for Non-Hospital Residential Rehabilitation providers using 7- and 30- day follow-up measures by January 1, 2021, to increase FUI rates for all members with SUD.
Intervention #4.2: Ensure substance use provider adherence to providing timely access to follow-up appointments by implementing a Secret Shopper monitoring program beginning January 1, 2021, to increase FUI rates for all members with SUD in outpatient programs. PDSA Cycles were completed in Q3 and Q4 2021, and in Q2 2022 for Secret Shopper intervention improvement opportunities. These are included in part 2 of Section 5, below. This work included the PIP planning group, the CBH QI Committee (CBH and provider agency staff) and feedback from providers who had been requested to complete Secret Shopper RCAs. Modifications include: 1. Addition of a dedicated voicemail for collection of provider responses when a message must be left to establish contact. 2. A review process for ensuring that the Provider Directory (source for provider contact info) is updated when needed, and the Provider Representatives are aware of access barriers. 3. Standardization of the RCA request, response tracking, and response review process.
Intervention #5.1: Increase use of evidence-based treatment by aligning MAT expectations with CBH's VBP Programs by January of 2021 to increase MAT-OUD rates for all members with OUD. As part of the ASAM transition and VBP program, Outpatient Substance Use providers will be monitored on MAT-OUD to ensure that members are offered or referred for counseling and medication assisted treatment. Monitoring was completed during 2021, however, VBP implementation was delayed until April 1, 2022, as a result of the continued Covid-19 Public Health Emergency. Relevant 2021 data was shared with providers during Q2 2022, and initial payments for VBP will be completed during Q3 2022. Additional interventions are being developed to address this barrier.
Intervention #6.1: Increase Equitable Delivery of Evidence-Based MAT for OUD provided to Black, non-Hispanic members, across the full provider network. Identify providers who are disproportionally offering counseling only and request RCAs and QIPs to ensure providers are offering evidence-based MAT options. Data was collected and analyzed during 2021, however, clarity on analysis of poor-performing providers was not achieved until Q1 2021 data was completed in Q3 2021. The RCA request and review process was further delayed into Q4 2021 and Q1 2022. During Q2 2022, remaining 2021 data analysis was completed, along with RCA requests and reviews. Additional interventions are being developed to address this barrier.
Intervention #6.2: To Increase community awareness of treatment needs and resources CBH held a workshop at the Faith and Spiritual Affairs Conference in Philadelphia in April of 2023. CBH focused on creating partnerships opportunities for faith-based organizations and SUD treatment providers by participating in the annual DBHIDS Faith & Spiritual Affairs Conference. The Chief Medical Officer from DBHIDS served as an expert speaker for this in-person event (no virtual component) with a PowerPoint presentation used to share educational material on the Opioid crisis, MAT OUD, and treatment utilization disparities with engaged regional faith leaders and provider staff. The session included an interactive component, with attendees working in small groups to plan local efforts to meet community needs in reducing stigma and encouraging the use of behavioral health supports, including MAT. Conference attendees shared their perception of the Opioid crisis and MAT OUD before and following the education session.
Intervention #7.1: Provide vaping education for providers, schools, and students by utilizing Single County Authority (SCA) prevention program in Philadelphia public, parochial and charter middle and high schools by February 2021 year to minimize use of vapor products in middle and high school students. Providers who are contracted with SCA will be invited to an education session with an expert speaker from the Philadelphia Department of Public Health on Vaping. The session will be conducted via zoom and a link to a vaping toolkit developed by the SCA, will be provided. **Intervention was Terminated as indicated in Q2 2022 Report**
Intervention #7.2: Increase provider awareness of best practices to identify and treat vaping in Middle/High School Age Population by providing education to CBH Behavioral Health Provider Network by March 2021. BH providers will

Summary of Interventions
be invited to an educational session with an expert speaker from the Philadelphia Department of Public Health on vaping and middle/high school age population. A provider notice will be distributed with information on the importance of addressing vaping in this population and a link to resources will be maintained on the CBH website, specifically for provider use, to reduce vaping. Impact of this intervention activity has not been maintained over time. Difficulty in accessing web utilization data and in linking it to the January 2021 webinar have been identified as barriers to this intervention's effectiveness. Additional interventions are being developed to address this barrier.
Intervention #7.3: Provide vaping education for Philadelphia public, parochial and charter middle and high school students by utilizing "Catch My Breath" (CMB) as a primary prevention program element during 2023. Providers who are contracted with SCA will enhance relationships with schools to ensure regular curriculum delivery. SCA will monitor progress and opportunities for expansion.
Intervention #8.1: Maintain MHR at or below 2.5% for all members with SUD, thereby improving retention. Monitor MHR rates quarterly and if rate rises above threshold, identify outlier OP SUD providers with claims for members readmitted within 90 days. Request RCA/PIP as needed to support engagement and retention. UPDATE: Intervention terminated due to updated CY 2020 data demonstrating MHR rate under 1%. See comments in next section.
CCBH
Intervention #PHa: MAT Toolkit: Address lack of SUD treatment engagement through education on SUD Treatment options for members, families, and providers through development and dissemination of a MAT Toolkit available beginning mid-year 2021 designed to increase rates of MAT prescribing **Intervention #PHb: Anti-Stigma Campaign:** Reduce stigma for seeking help for SUD resulting in more members engaging in SUD care via an anti-stigma campaign utilizing education, targeted media posts, webinars, and community outreach launching mid-year 2021; focus on Black/African American racial disparities; build upon recent SUD education efforts with community partners (e.g., Voice and Vision, Steel Smiling, Inc.) and collaborations with community partners and others to expand educational anti-stigma programs such as Mental Health First Aid
Intervention #1a: **Warm Hand Off (WHO):** Increase the percent of members when presenting at PH hospitalization or ED who initiate SUD treatment including MAUD and MOUD over 36 months, by bridging the gap between PH and SUD systems through a WHO by peers and case managers of SCAs, COEs, or other contracted providers. (Note: WHOs in counties with a larger percentage of members that identify as Spanish speaking have bilingual staff or offer translation services for non-English speaking members). **Intervention #1b**: **Telehealth Bridge Clinic:** Over 36 months, increase the rate of billed telehealth claims for prescribing MAUD/MOUD for members with OUD and AUD during or immediately following an inpatient PH hospitalization or ED through untapped prescribing services via telehealth designed to engage individuals into SUD treatment. (Note: translation services are available for members that are non-English speaking). **Intervention #1c**: **FQHC Learning Community:** Increase the percent of individuals seeking primary care in FQHCs with screening and initiation of SUD treatment including MAUD/MOUD through support, education, and consultation in a 12-month learning community.
Intervention #2a: **High Risk Care Management Interview (HRCM):** Over 36 months, increase follow up (FUI) and decrease readmission (MHR/SAR) through engagement by a Community Care manager before BH discharge to address factors associated with inpatient SUD utilization or detox and facilitate referral and connection to BH service or other community supports. Embedded within this intervention is a mandatory cultural awareness training for all HR CMs. (Note: the HR interview is available in Spanish. Additionally, translation services are available for members that are non-English speaking).

Summary of Interventions
Intervention #2b: **Community Health Worker Outreach (CHW):** Over 36 months, increase follow up (FUI) and decrease readmission (MHR/SAR) through outreach by a Community Care CHW following inpatient SUD or detox within 30 days to educate member on care options, facilitate referral and connection to BH service or other community supports. Embedded within this intervention is a mandatory cultural awareness training for all CHWs. (Note: translation services are available for members that are non-English speaking). **Intervention #2c: Taper to Induction:** Over 36 months, provide education and training through a Taper to Induction protocol to increase the number of providers who offer education, referral, or direct access to all MATs supported through an alternative payment arrangement to support need for increased medical monitoring with MAT; record reviews with SUD providers to confirm MAT education/access is being completed. (Note: translation services are available for members that are non-English speaking).
Intervention #3a: Family/Social Support Over 24 months, provide education, trainings, and toolkits including racial and ethnic cultural competencies, to members and their families to increase rates at which members include their families in SUD outpatient treatment as evidenced by increased rates for billed family therapy sessions delivered to fidelity to best practice standards in family therapy. (Note: translation services are available for members that are non-English speaking). **Intervention #3b**: **Recovery Management Checklist (RMC):** Over 24 months, implement ongoing monitoring by CRS to improve retention in care, provide education in relapse prevention, racial and ethnic cultural competencies, connection to community-based resources, with payment reform to support long-term monitoring of members in SUD treatment. (Note: the RMC is available in Spanish. Additionally, in counties with a larger percentage of members that identify as Spanish speaking providers have bilingual staff; translation services are available for non-English speaking members).
MBH
Intervention 1a Discharge Planning Initiative: Improve discharge planning practices among 24-hr SUD providers (What?) by educating them about MBH's discharge planning best practices which are informed by Project RED, incorporating these discussions into the care management process, and ensuring that this has been documented by requiring the documentation of 10 separate components (How?). A sample of discharges will be audited each month to measure and ensure improvement in adherence to the best practices, and providers will receive ongoing feedback on their performance during the calendar year (When?) This is expected to impact the Inadequate Discharge Planning barrier bundle and in turn have a positive effect on follow-up and readmission rates (Why?).
Intervention 1b Component of Discharge Planning Initiative: Addressing Cultural Factors Improve discharge planning practices among 24-hr SUD providers (What?) by requiring attention to and discussion about the individual's cultural factors that could impact follow-up and recovery by incorporating this discussion into the care management process and ensuring this has been documented (How?). In the monthly audits described for Intervention 1a, a separate score for "cultural factors" will be calculated and reported monthly during the year (When?). This is expected to impact the Cultural Competency barrier bundle, and in turn have a positive effect on follow-up and readmission rates (Why?)
Intervention 1c Component of Discharge Planning Initiative: Addressing Transportation Barriers Improve discharge planning practices among 24-hr SUD providers (What?) by requiring attention to and discussion about the individual's transportation barriers and resources that could impact follow-up and recovery by incorporating this discussion into the care management process and ensuring this has been documented (How?). In the monthly audits described for Intervention 1a, a separate score for "transportation" will be calculated and reported monthly during the year (When?). This is expected to impact the Transportation barrier bundle, and in turn have a positive effect on follow-up and readmission rates (Why?)
Intervention 1d:

Summary of Interventions
Component of Discharge Planning Initiative: Addressing Relapse Prevention Planning Improve discharge planning practices among 24-hr SUD providers (What?) by requiring attention to and discussion about the individual's relapse prevention plan by incorporating this discussion into the care management process and ensuring this has been documented (How?). In the monthly audits described for Intervention 1a, a separate score for "relapse prevention planning" will be calculated and reported monthly during the year (When?). This is expected to impact the Inadequate Relapse Prevention Planning barrier bundle, and in turn have a positive effect on follow-up and readmission rates (Why?)
Intervention #2a: CRS Provider Collaboratives Enhance the knowledge, competency, and confidence among CRS providers (What?), by engaging them in educational and supportive online collaboratives. Special attention is to be paid to working with people with co-occurring disorders. Certified Peer Specialists (CPSs) who work with MH consumers will also be invited, so that CRS and CPS providers can learn from and support each other. Magellan will pursue continuing education accreditation from the Pennsylvania Certification Board. (How?). Collaboratives will occur on a quarterly basis (When?), to help CRS providers to best serve members and thereby increase engagement and retention, and ultimately improve follow-up and readmission rates (Why?)
Intervention #2b: CRS Provider Collaboratives: Enhance the cultural competency among CRS providers and their ability to convey this to members who are different from them (What?), by engaging them in educational and supportive online collaboratives as described above (How?), on an quarterly basis (When?), so that they can best serve members of different races and ethnicities and thereby increase the numbers of members who are Black/African American and Hispanic in CRS services and their retention in services (Why?).
Intervention #3: Incentivizing Co-Occurring Competence Effort: Improve co-occurring competence among dually licensed (MH/SUD) outpatient providers (What?) by developing and applying an assessment instrument containing objective standards, measuring outcomes, and scoring providers on performance. This will eventually lead to assigning providers to tiers based on their data and setting reimbursement rates for providing integrated care to members with COD (How?). In Year 1, Magellan will engage providers and educate them, providers will complete a self-assessment, Magellan will review and score providers according to evidence submitted and assign baseline scores. Then the value-based implementation will begin in 2022. (When?). This will primarily address the barrier of the separation of MH and SUD services (Why?).
Intervention #4: Motivational Interviewing Training Series: Improve therapeutic alliance between members and providers (What?) by educating providers about specific applications of Motivational Interviewing principles, specifically addressing interventions with Pre-Contemplation, relapse, and leaving services. Subject matter experts will be contracted to provide the trainings and continuing education accreditation will be pursued with the Licensing Board and PCB. Pre-test and follow-up post-test surveys will be conducted to assess knowledge gained and the application of it. (How?) Online training seminars will begin April 2021 and occur 3 times per year through 2023. (When?) This is anticipated to increase provider ability to intervene effectively with members who are at various stages of change, and especially those at Pre-Contemplation and Relapse/Recurrence stages, in order to improve rates of engagement, retention, follow-up and readmission (Why?).
Intervention #5: Communication with Freestanding (non-behavioral health) MAT Providers: Increase the rates of members on MAT who also participate in some form of counseling (What?). Identify the existing non-contracted MAT prescribers ("freestanding" MAT providers who prescribe buprenorphine) in each Magellan contracted county and send them information about behavioral health resources to which they may refer their MAT patients. Also request that they contact Magellan via e-mail in order to receive electronic communication (How?) Magellan will gather updated information on these providers and their contact information twice per year and send out information via mail and e-mail twice per year, beginning in 2021 and continuing through 2023 (When?). It is hoped that this intervention will have some degree of positive impact on MAT-OUD and MAT-AUD rates (Why?)
Intervention #6: Prevention of AMA Discharges Effort: Improve retention in SUD treatment by reducing AMA/AWOL discharges from 24hr SUD services. (What?) Magellan will establish a new measure—"AMA/AWOL discharge rate" for high-intensity SUD providers (levels 3.5/3.7/4.0) and

Summary of Interventions
track this monthly by provider. At the same time, Magellan will gather information on what interventions providers are using to prevent AMAs/AWOLs and provide resources on "AMA blocking" to providers. Minimum standards for discharge planning with AMA discharges will be established and included in the discharge audits mentioned in Intervention 1. (How?) A new report is being designed in Q3 of 2020, to be tracked regularly beginning Q1 2021 that will identify AMA/AWOL rates overall and by provider. Education with providers on minimum expectations around discharge planning with AMA discharges and on AMA blocking will begin March 2021. The audits of AMA discharges for minimum adherence to best practices will begin as stated in Intervention1, in Q2 2021 (When?). This is anticipated to result in decreased AMA/AWOL rates, meaning increased retention, and also in improved follow-up rates and readmission rates (Why?)
Intervention #7: Prevention Activities: Magellan will aim to prevent SUDs and progression of SUD severity (what?) by engaging in 4 information dissemination prevention activities targeting populations identified by contractors and Magellan (How?). Magellan plans to have articles on these topics, along with how to seek help, published in Pennsylvania based newspapers, and share this information in electronic/virtual/online platforms during calendar year (When?) This is anticipated to impact prevention and early detection of SUDs, which are primary goals of the PIP (Why?)
PerformCare
Intervention #1a: Clinical Care Managers (CCM) and Member Services will utilize the SU Evidence-Based Treatment Internal Resource guide listing evidence-based treatments and trauma informed care offered by SUD Non-Hospital Rehab providers. This will support & guide Members and referral sources seeking treatment to link to the services providing the evidence-based treatment and trauma informed care that best meet the Member needs and ensure Members receive the services that will better enable them to make clear and informed treatment decisions and improve participation in treatment post discharge.
Intervention #1b: PerformCare Quality Performance Specialist will ensure the above SU Evidence-Based Treatment Internal Resource guide is posted to the PerformCare website. This will allow Members receiving SU treatment and referral sources to link to the services providing the evidence-based treatment and trauma informed care that best meets the Member needs and ensures Members receive the services that will better enable them to make clear and informed treatment decisions and improve participation in treatment post discharge.
Intervention #1c: PerformCare will expand the number of in-network substance use provider sites that offer induction of Medication Assisted Treatment to increase access to Medication-Assisted Treatment (MAT) for PerformCare Members who are diagnosed with an OUD or AUD diagnosis. Providers targeted for this intervention include substance use residential providers serving 30 or more Members and substance use outpatient, intensive outpatient providers and partial hospitalization providers serving 100 or more Members. PerformCare will collaborate with CABHC to utilize reinvestment funding to for expansion and SCAs will outreach to provider sites where MAT is not provided to educate the providers on the availability of reinvestment dollars to support expansion.
Intervention #2a: The Certified Recovery Specialist (CRS) level of care is uniquely qualified to support Members in addressing multiple life demands, SDOH needs and ongoing support of Member's recovery. In order to increase Member engagement in CRS Services, PerformCare Clinical Department will hold an educational provider meeting to discuss PerformCare's expectation that providers complete referrals to Certified Recovery Specialists (CRS) for each Member with SDOH needs and multiple life 'demands'. This educational provider meeting will focus on engaging SU Non-Hospital Rehab facilities to support Members in the transition to the community following discharge.
Intervention #2b: PerformCare Network Operations will strongly encourage ALL providers to complete Z-codes on all claims submissions via provider Memo and AE notifications. PerformCare will offer a webinar for providers addressing how to submit z-codes. Obtaining only 9.5% of claims with z-code data limits PerformCare's ability to identify, trend and address the SDOH needs of the larger Member population. Based on collected data, PerformCare will develop interventions and Care Management strategies to address Member social determinant needs.
Intervention #3a: PerformCare Network Providers will utilize a toolbox of resources provided by PerformCare when screening, treating and referring Members to appropriate treatment. This toolbox of resources includes the Clinical Practice Guidelines, screening and assessment tools for specific diagnoses and available evidence-based programming

Summary of Interventions
and trauma informed care programs. The Provider will ensure that the Member is connected to MH or SU treatment as identified through the use of the screening and assessment toolbox.
Intervention #3b2 Percentage of all PerformCare Member Services staff and Utilization Management staff who identify at using the substance use internal resource guide at least monthly.
Intervention #4a: The PerformCare, CABHC, and TMCA PIP workgroup will develop a Provider Advisory Board chaired by the PerformCare Medical Director or Psychologist Advisor to gather information regarding the precipitators of the identified disparities. The Provider Advisory Board will have representation from each SU level of care provided by PerformCare Network Providers, MH Outpatient Network Providers, Individuals in Recovery, PerformCare Inter-department associates and Primary Contractors. PerformCare and the Primary Contractors will identify the goal of the Provider Advisory Board. The Provider Advisory Board will meet twice yearly to analyze Race and Ethnicity data including specific Member feedback from survey responses, develop and implement opportunities and activities to support reducing racial and ethnic disparities.
Intervention #4b: The PerformCare, CABHC and TMCA PIP workgroup will develop a Provider Cultural Humility and Awareness Survey to gather information regarding the precipitators of the identified disparities and provider current practices to address racial and ethnic disparities. The Survey will be dispersed to PerformCare Network Providers and used for development of Intervention 4c.
Intervention #4c: PerformCare Psychologist Advisor and PerformCare Manager of Consumer and Family Affairs will develop and implement a Provider Cultural Humility and Awareness Training. The training will be provided to PerformCare Network Providers. PerformCare will measure the impact through a Training Evaluation Survey and Individual Member feedback.
Intervention #5a: PerformCare Network Operations will identify Outpatient Providers willing to expand programming to treat Members with both SU and MH needs through a Provider Survey to better meet Members co-occurring needs.
Intervention #5b: PerformCare Provider Network Operations will develop and make available on the PerformCare website a provider listing of Outpatient Providers offering both MH and SU treatment for Members seeking treatments to best meet their co-occurring needs.
Intervention #6a: PerformCare Network Operations will complete a survey of HWH providers to assess readiness for transition to acceptance of FDA approved MAT that aligns with ASAM/DDAP expectations that Members with MAT can access all DDAP levels of care to determine barriers to implementation. PerformCare will offer support to providers to overcome those barriers.
Intervention #6b: PerformCare Clinical Administrative Support will outreach to HWH providers in September 2021 to collect data regarding the acceptance of FDA approved MAT that aligns with ASAM/DDAP expectations that Members with MAT can access all DDAP levels of care. PerformCare will update the resource available to Members.
Intervention #7a: PerformCare Network Operations will develop a Best Practice Discharge Planning landing page on the PerformCare website. PerformCare Network Operations will send an iContact communication that directs Network Providers to the PerformCare website for information about the Teach Back and Discharge Management Planning (DMP) postings to increase provider utilization of Best Practice Discharge Planning and Member involvement in the Best Practice Discharge Planning process.
Intervention #8a: PerformCare Quality Department will complete a mailing to all parents/guardians of Members ages 6-10 with a depressive disorder diagnosis notifying the parent/guardian of Prevention Resources including risk of SUD for children with a depressive disorder diagnosis, SUD screening for children, Social Developmental Strategies and available Prevention Programs within each PerformCare county. PerformCare will complete an annual survey of parents/guardians measuring awareness of SUD risk factors and available Prevention programs. *See Appendix P Prevention Program Outline for additional information about this Prevention Program.
Intervention #8b: PerformCare Quality Department will develop an SUD Prevention landing page on the PerformCare website. PerformCare Network Operations will send an iContact communication that directs Network Providers to the PerformCare website for information about SUD screening for children ages 6-10, Social Development Strategies and available Prevention Programs within each PerformCare county.

Summary of Interventions
Intervention #8c PerformCare Quality Department will provide an educational brochure and SUD checklist to FQHC providers outlining the increased risk of SUD for children with a depressive disorder diagnosis and directing the providers to access the SUD Prevention landing page on the PerformCare website for SUD checklist options for children, Social Developmental Strategies and available Prevention Programs. PerformCare will collaborate with FQHC providers to distribute these materials to all applicable FQHC patients. PerformCare will track distribution of the educational brochure.
Intervention #8d PerformCare Quality Department will collaborate with FQHC providers to develop educational social media posts outlining the increased risk of SUD for children with a depressive disorder diagnosis and directing the social media users to access the SUD Prevention landing page on the PerformCare website for SUD options for children, Social Developmental Strategies and available Prevention Programs. PerformCare will work together with FQHC providers to distribute these materials through social media to the wider community. PerformCare will track unique views of the social media educational posts.
Intervention #9a: PerformCare will connect a current SU OP provider that has embedded CRS with a SU IP provider. The CRS will meet Members admitted to SU IP and support the Member through the transition from SU IP to SU OP.

CHC Performance Improvement Project Interventions

As referenced in **Section I: Performance Improvement Projects**, **Tables A4–A7** list all the interventions outlined in the MCO's most recent PIP submission for the review year.

Table A4: CHC-MCO – ACP PIP Interventions

Summary of Interventions
ACP – Strengthening Care Coordination
Intervention #1a: Collaborate with key stakeholders with ClinConnect and other HIE organizations (potentially eVantage, HSX, KeyHIE, and LGH) to develop the necessary agreements and processes to capture the data needed for our Participants. Goal completion day by fourth quarter of 2021.
Intervention #2a: Strengthen relationships with the DSNPs in PA in order to promote timely, Participant engagement following discharge through obtaining data exchange agreements with HIE organizations, D-SNPs, and BH-MCO along with continued education for our staff to enhance the service coordination program. **Intervention #2b:** Collect data to help ensure appropriate care transition when a Participant utilizes the Emergency Room for care. The MCO's Care Management and SC teams will educate Participants on the proper use of ER, establish guidelines for use of transportation pre-scheduling for follow-up care, and to keep open lines of communication with the MCO.
Intervention 3a: Provider Network department will work collaboratively with area hospitals to educate on the effectiveness of shared data and encourage the exchange in a timely manner to promote reduced readmission rate for MCO Participants. **Intervention 3c:** Service Coordinators will conduct an in-person visit within 2 business days after notification of discharge from a hospital and develop or update PCSP to ensure it is person-centered and meeting the needs of the Participant through data agreements and increased communication between MCO and the Participants. **Intervention 3d:** Educate providers to enter missed shifts due to hospitalizations as soon as they are made aware. The Service Coordinator will review the Missed Shift report on a weekly basis to capture the notifications in order to address potential gaps in care. **Intervention #3e:** Collect data to help ensure appropriate care transition when a Participant is admitted to an acute hospital. The MCO's Care Management and SC teams will educate Participants on the guidelines for use of

Summary of Interventions
transportation pre-scheduling for follow-up care and to keep open lines of communication with the MCO. Educate SCs to provide contact information to the Participant so the Participant will notify the SC of an admission.
Intervention #4a: Strengthen relationships with the BH MCOs in SW PA in order to promote timely, Participant engagement following discharge. **Intervention #4b:** Educate Participants and caregivers on importance of immediate notification to their SC if admitted to a BH facility. Provide visual reminders to Participants, such as a magnet with the SC name, contact information and 24-hour phone number for MCO.
Intervention #5a: Service coordinator will visit the Participant within 14 days of discharge to review care plan and any changes following notification of discharge in an effort to decrease the risk of readmission. **Intervention #5b:** Following notification of discharge from a hospital or BH facility the SC will review with the Participant their care plan and revise, as necessary. **Intervention #5c:** Provide Participant education via Participant Newsletter, reminder notecard in home and ad hoc mailing on the importance of notifying the SC following a discharge from a hospital or behavioral health facility.
Intervention #6a: Educate SC on ways to convey to Participants the importance and on value of care coordination and agreeing to have their BH information shared with the MCO.
ACP – Transitions of Care
Intervention #1a: Educate Nursing Facility Administration on the benefits of proper discharge/ transition planning and coordination between MCO and the administrative staff to improve percent of participants who are discharged from the nursing facility with a viable person-centered care plan from baseline to final measurement. **Intervention #1b:** Educate Service Coordinators on rapport building techniques for use in building relationships with Nursing Facility staff in order to be included in the PCPT process for the participants in the nursing facility.
Intervention #2a: Educate the participant on the role of unmet behavioral health needs may have on their ability to remain in the community and on available behavioral health benefits.
Intervention #3a: Provide education to the participant and/or caregiver on the benefits of consenting to the offered services and resources to enhance the potential for success in the community.
Intervention #4a: Reimburse providers that rendered services to a Participant during the eligibility process (new eligibility process). If NHT visits with the participant and performs attendant care and basic services, and there is no payer, the MCO may reimburse. Plan is agreeing to pay for agreed-upon services as long as it is part of the PCSP when they are retrospective. Details and criteria will be developed and established in a process flow (e.g., in-network provider, service is on the PCSP). The MCO will coordinate with the Commonwealth's Nursing Home Transition and Money Follows the Person.
Intervention #5a: Strengthen relationships with the D-SNPs in PA in order to promote timely, participant engagement following discharge. **Intervention #5b:** Implement a communication process in place with other health plan care manager or the discharge planner when there is no care manager, to coordinate discharge planning and provision of support services under the LTSS benefit to avoid duplication of services. **Intervention #5c:** Strengthen relationships with the nursing facilities and educate regarding the importance and process of notifying the MCO within 24 hours of participant admission and/or discharge.
Intervention #6a: Strengthen relations with the participant's caregiver and members of their PCPT in order to provide the best options, including the MCO's Welcome Home Benefit, for their identified needs while in the community.

Summary of Interventions
Intervention #6b: Conduct an assessment of the participant's living situation prior to discharge from a nursing facility to identify the need for any LTSS services upon transition to the community. **Intervention #6c:** Following discharge from a nursing facility the SC will, if necessary, facilitate scheduling of appointments.
Intervention #7a: Participant education during new member orientation to notify their SC on the day of or day after admission if they are admitted to a NF. **Intervention #7b:** CIS and SCs will review HIE admission data for use in identifying admissions to the NF.

PIP: performance improvement project; ACP: AmeriHealth Caritas Pennsylvania; CHC: Community HealthChoices; HIE: Health Information Exchange; D-SNP: dual eligible special need plan; BH: behavioral health; MCO: managed care organization; SC: service coordination; ER: emergency room; SW: southwest; PA: Pennsylvania; LTSS: long-term services and supports.

Table A5: CHC-MCO – KF PIP Interventions

Summary of Interventions
KF – Strengthening Care Coordination
Intervention #1a: Collaborate with key stakeholders with ClinConnect and other HIE organizations (potentially eVantage, HSX, KeyHIE, and LGH) to develop the necessary agreements and processes to capture the data needed for our Participants. Goal completion day by fourth quarter of 2021.
Intervention #2a: Strengthen relationships with the D-SNPs in PA in order to promote timely, Participant engagement following discharge through obtaining data exchange agreements with HIE organizations, D-SNPs, and BH-MCO along with continued education for our staff to enhance the service coordination program. **Intervention #2b:** Collect data to help ensure appropriate care transition when a Participant utilizes the Emergency Room for care. The MCO's Care Management and SC teams will educate Participants on the proper use of ER, establish guidelines for use of transportation pre-scheduling for follow-up care, and to keep open lines of communication with the MCO.
Intervention #3a: Provider Network department will work collaboratively with area hospitals to educate on the effectiveness of shared data and encourage the exchange in a timely manner to promote reduced readmission rate for MCO Participants. **Intervention #3b:** Service Coordinators will conduct an in-person visit within 2 business days after notification of discharge from a hospital and develop or update PCSP to ensure it is person-centered and meeting the needs of the Participant through data agreements and increased communication between MCO and the Participants. **Intervention #3c:** Educate providers to enter missed shifts due to hospitalizations as soon as they are made aware. The Service Coordinator will review the Missed Shift report on a weekly basis to capture the notifications in order to address potential gaps in care. **Intervention #3d:** Collect data to help ensure appropriate care transition when a Participant is admitted to an acute hospital. The MCO's Care Management and SC teams will educate Participants on the guidelines for use of transportation pre-scheduling for follow-up care and to keep open lines of communication with the MCO. Educate SCs to provide contact information to the Participant so the Participant will notify the SC of an admission.
Intervention #4a: Strengthen relationships with the BH MCOs in SW PA in order to promote timely, Participant engagement following discharge.

Summary of Interventions
Intervention #4b: Educate Participants and caregivers on importance of immediate notification to their SC if admitted to a BH facility. Provide visual reminders to Participants, such as a magnet with the SC name, contact information and 24-hour phone number for MCO.
Intervention #5a: Tracking and trending response rates of Participants allowing a Service Coordinator visit following a discharge has been identified. **Intervention #5b:** Following notification of discharge from a hospital or BH facility the SC will review with the Participant their care plan and revise, as necessary. **Intervention #5c:** Provide Participant education via Participant Newsletter, reminder notecard in home and ad hoc mailing on the importance of notifying the SC following a discharge from a hospital or behavioral health facility.
Intervention #6a: Educate SC on ways to convey to Participants the importance and on value of care coordination and agreeing to have their BH information shared with the MCO.
KF – Transitions of Care
Intervention #1a: Educate Nursing Facility Administration on the benefits of proper discharge/ transition planning and coordination between MCO and the administrative staff to improve percent of participants who are discharged from the nursing facility with a viable person-centered care plan from baseline to final measurement. **Intervention #1b:** Educate Service Coordinators on rapport building techniques for use in building relationships with Nursing Facility staff in order to be included in the PCPT process for the participants in the nursing facility.
Intervention #2a: Educate the participant on the role of unmet behavioral health needs may have on their ability to remain in the community and on available behavioral health benefits.
Intervention #3a: Provide education to the participant and/or caregiver on the benefits of consenting to the offered services and resources to enhance the potential for success in the community.
Intervention #4a: Reimburse providers that rendered services to a Participant during the eligibility process (new eligibility process). If NHT visits with the participant and performs attendant care and basic services, and there is no payer, the MCO may reimburse. Plan is agreeing to pay for agreed-upon services as long as it is part of the PCSP when they are retrospective. Details and criteria will be developed and established in a process flow (e.g., in-network provider, service is on the PCSP). The MCO will coordinate with the Commonwealth's Nursing Home Transition and Money Follows the Person.
Intervention #5a: Strengthen relationships with the D-SNPs in PA in order to promote timely, participant engagement following discharge. **Intervention #5b:** Implement a communication process in place with other health plan care manager or the discharge planner when there is no care manager, to coordinate discharge planning and provision of support services under the LTSS benefit to avoid duplication of services. **Intervention #5c:** Strengthen relationships with the nursing facilities and educate regarding the importance and process of notifying the MCO within 24 hours of participant admission and/or discharge.
Intervention #6a: Strengthen relations with the participant's caregiver and members of their PCPT in order to provide the best options, including the MCO's Welcome Home Benefit, for their identified needs while in the community. **Intervention #6b:** Conduct an assessment of the participant's living situation prior to discharge from a nursing facility to identify the need for any LTSS services upon transition to the community. **Intervention #6c:** Following discharge from a nursing facility the SC will, if necessary, facilitate scheduling of appointments.

Summary of Interventions
Intervention #7a: Participants are educated during new member orientation to notify their SC on the day of or day after admission if they are admitted to a NF. **Intervention #7b:** The CIS and SCs will review HIE admission data for use in identifying admissions to the NF.

PIP: performance improvement project; KF: Keystone First; CHC: Community HealthChoices; HIE: Health Information Exchange; D-SNP: dual eligible special need plan; BH: behavioral health; MCO: managed care organization; SC: service coordination; ER: emergency room; SW: southwest; PA: Pennsylvania; LTSS: long-term services and supports.

Table A6: CHC-MCO – PHW PIP Interventions

Summary of Interventions
PHW – Strengthening Care Coordination
Develop a data sharing agreement with all BH MCOs which will provide a daily feed of BH inpatient admissions to PHW.
Develop and use of a template for all clinical information available. The template can be used as a communication tool between providers and as a piece of the PCSP template. Design a clinical information resource document which follows AHRQ IPASS format. IPASS stands for Introduction, Patient, Assessment, Situation and Safety. PHW will work with internal stakeholders to define relevant clinical information to be presented in the resource document. Design an outbound fax template following the IPASS format which will provide consistent, structured information to the fax recipients. This intervention will be piloted with Utilization Management and Pharmacists who complete Medication Reconciliations.
Develop user-friendly communication pieces for transfer of information between departments and between internal and external partners.
Contract with Health Information Exchanges (HIEs) to link the electronic medical record (EMR) systems of different hospital health systems and other healthcare providers to make clinical information readily accessible for care management.
The Service Coordinator (SC) or External Service Coordinator (SCE) will perform an in-person comprehensive reassessment following Participant discharge. The transition of care coordinator will receive notification of the discharge and task the SC or SCE to schedule the in-person reassessment.
The transition of care (TOC) nurse will begin discharge planning activities within 24 hours of notification of admission. A phone call to the Participant or hospital by the TOC nurse will be placed to coordinate discharge back to the home setting. The transition of care (TOC) nurse will initiate post-discharge outreach within 72 hours of notification of discharge. The TOC nurse will communicate directly with the participant to identify any barriers to a return to the home setting. The transition of care (TOC) nurse will initiate post-discharge outreach within 10 days of notification of discharge. The TOC nurse will communicate directly with the participant to support the transition back to the home setting.
The Transition Coordinator, upon receipt of the 079 discharge report, tasks the Utilization Management (UM) Nurse to retrieve the discharge summary for the participant if the discharge report is not already available. The UM Nurse will call the acute inpatient facility to request discharge information. PHW will develop data exchange relationships with D-SNPs and HIEs to secure participant ADT notifications for non-aligned Participants.

Summary of Interventions
PHW Transition Coordinators to initiate the process of requesting pre-admission medication list from the PCP once made aware of a participant admission to the hospital. Once PHW is aware of a discharge the Transition Coordinator initiates attempts to obtain the discharge medication list (and pre-admission list if not already received). Once both lists are obtained, they are sent to the Pharmacist if the Participant has 10 or more medications or to a Registered Nurse if they have 9 or fewer. The Med Reconciliation is completed and faxed to the PCP within 28 days.
PHW – Transitions of Care
PHW makes a referral to the Independent Enrollment Broker (IEB) as soon as NHT candidates are identified. PHW notifies Maximus of the discharge date and Participant's address 14 days prior to the discharge date. Maximus provides that information to the County Assistance Office for waiver approval.
In the SW and SE Regions: SC will discuss potential discharge with NF Participants at New Participant Orientation (NPO); SC/CM/PC to educate Participant, family, caregivers and physician on home-based services and ways to support the participant in the community; and PHW will Connect Participant with Tri-County Patriots for Independent Living (TRIPIL) for peer-to-peer/community integration services.
PHW will conduct Peer-to-Peer (PTP) discussions between a PHW Medical Director and the Participant's PCP in the community prior to the Participant's first PCP visit. The call will include a review of the problem list, medication review/reconciliation, needed community support services and other components of the discharge plan. As part of the enhanced discharge planning process, the SC/SCEs will review the final NF discharge plans with the Participant and/or caregiver prior to discharge. Implement a weekly multidisciplinary team meeting to discuss Participants who have an anticipated transition date. The goal is to ensure that the HCBS needs have been determined and to ensure that all services are in place and Durable Medical Equipment (DME) have been purchased and/or completed along with all required authorizations. The SC will complete an in-person comprehensive reassessment within 14 business days of NF discharge for Participants. The SC will attempt to be in person with the Participant at the time of transition and conduct the comprehensive InterRAI assessment.
PHW will refer all Participants identified as needing housing to transition from the NF to a Community Partner (Centers for Independent Living, Voices for Independence, and Abilities in Motion). The Community Partner assists Participants in identifying affordable and accessible housing by identifying appropriate housing which includes filling out applications to get Participants on waiting lists. The PHW NHT Program Coordinator meets with the community partners weekly to ensure ongoing communication on progress securing housing for the Participants.
In the NW, NE, and LC Regions: At the time of discharge from the NF, the SC will copy the medication list from the NF and the discharge medication list. The SC will fax the medication lists to the Quality department that same day or the day after discharge. Quality will send to the Transitions of Care Team for completing and documenting the medication reconciliations and fax to the Participant's PCP.

PIP: performance improvement project; PHW: Pennsylvania Health and Wellness; BH: behavioral health; MCO: managed care organization; AHRQ: Agency for Healthcare Research and Quality; IPASS: introduction, patient, assessment, situation, and safety; D-SNP: dual eligible special need plan; SW: southwest; SE: southeast; NF: nursing facility; HCBS: Home and Community-Based Services; NW: northwest; NE: northeast; L/C: Lehigh/Capital.

Table A7: CHC-MCO – UPMC PIP Interventions

Summary of Interventions
UPMC – Strengthening Care Coordination
Improve the notification process to the NFCE participant's D-SNP care managers and the participant's SC within 1 business day of notification of inpatient admissions.

Summary of Interventions
Work with D-SNPs in the Southwest Region to allow for data exchange and care management to promote seamless transitions of care for the participant back to home.
Outreach to the participant within 2 business days of receiving notification of discharge (plus enhancements to expedited SC outreach, i.e., within 1 business day, within certain Regions).
Reduce failed discharges: the care manager attempts outreach to the participant at time of transition of care to provide aspects of care collaboration to meet the participant's needs, such as proactive discharge planning and readmission prevention, scheduling appointments, or connecting the participant to their service coordinator.
Standardization and timeliness (after discharge from an inpatient stay to home when participants are likely to need support for making and attending appointments, or other supports with ADLS and IADLs (plus enhancements to expedited and timely SC outreach within certain Regions).
Enhance the notification of admission process by utilizing EVV data.
Educate providers at high-volume PCP practices on the CHC population and provider expectations through meetings with UPMC Physician Account Executives (PAEs).
Enhance service coordination and care management in the NE, NW, and L/C Regions: ensure that the participant has a scheduled appointment with a practitioner following an inpatient discharge; review the participant's medications post-discharge; and assure the participant has the necessary medications and assist in obtaining the medications if necessary.
Engage the health systems in the L/C Region in involve UPMC in discharge planning to achieve successful transitions of care participants.
UPMC – Transitions of Care
Monitor participants in the SW Region discharged from PICs to participants residing in NFs not participating in PIC program.
Notification system for NFs to notify the MCO (and vice-versa) within 1 business day of participants desiring to transition to the community.
Enhanced meetings between the MCO service coordination and NF participant via quarterly visit to determine if they desire to transition home. Starting in March 2020 due to COVID-19, telephonic meetings integrated and monitored.
Enhanced service coordination by MCO to contact the participant within 1 business day to start the transition process.
After notification of the discharge date from the facility, the MCO will visit the participant in the home within 48 hours (plus in some regions, enhance with telephonic integration and monitoring starting in March 2020 due to COVID-19).
After notification of the discharge date from the facility, the MCO will enhance coordination to ensure services are set up prior to the transition date within 48 hours for participants (plus in some regions, enhance with telephonic integration and monitoring starting in March 2020 due to COVID-19).
After notification of the discharge date from the facility, the MCO will enhance coordination to ensure a service plan is set up within 48 hours for participants' visit or telephonic meeting (plus in some regions, further enhance with telephonic integration and monitoring starting in March 2020 due to COVID-19).
After notification of admission to the NF, the SC to begin enhanced discharge planning with the participant within the first 45 days of the NF stay in select regions.
Empower participants and/or families with communication tools/materials to successfully collaborate with the direct care worker/agency to have a positive, constructive, and engaging relationship in select regions.
Enhanced monitoring of participants discharged from PICs to participants residing in NFs not participating in PIC program in select regions.

PIP: performance improvement project; UPMC: UPMC Health Plan; D-SNP: dual eligible special need plan; SC: service coordinator; PCP: primary care provider; CHC: Community HealthChoices; NE: northeast; NW: northwest; L/C: Lehigh/Capital; SW: southwest; NF: nursing facility; MCO: managed care organization; COVID-19: 2019 novel coronavirus.