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Pennsylvania Health & Wellness

External Quality Review

Annual Technical Report

April 2024

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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 MCO. *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."

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 recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding health care quality, timeliness, and access, as well as make recommendations for 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 Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Long-Term Living (OLTL) contracted with IPRO, an EQRO, to conduct the 2023 EQR activities for MCOs contracted to furnish the Community Health Choices (CHC) program. CHC is the mandatory managed care program in PA for adults dually eligible for Medicare and Medicaid, older adults, and adults with physical disabilities, in need of long-term services and supports (LTSS). LTSS 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. During the period under review, report year 2023, Pennsylvania's CHC MCOs included Pennsylvania Health & Wellness (PHW). This report presents results of these EQR activities for PHW.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the four mandatory EQR activities that were conducted. 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.

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

(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 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 population.

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 MCOs' performance strengths and opportunities for improvement.

While the *CMS External Quality Review (EQR) Protocols* published in January 2023 stated that an information systems capability assessment (ISCA) is a required component of the mandatory EQR activities. CMS previously clarified 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. Findings from IPRO's review of the MCOs' HEDIS final audit reports (FARs) are in the **Validation of Performance Measures** section of this report.

Conclusions and Recommendations

IPRO used the analyses and evaluations of 2023 EQR activity findings to assess the performance of Pennsylvania Medicaid MCOs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

Findings from 2023 EQR activities highlight PHW's continued commitment to achieving the goals of the Pennsylvania Medicaid Quality Strategy. Strengths related to quality of care, timeliness of care, and access to care were observed in the implementation of performance improvement projects, performance measure rates, compliance with regulatory requirements, and quality of care survey scores; however, there were also important shortcomings in each that can be addressed through ongoing quality measurement, reporting, and improvement activities. **Table 26** provides specific information on PHW's strengths, opportunities, and IPRO recommendations for improvement.

II. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) Performance improvement projects establishes that the state must require contracted Medicaid 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 *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, Pennsylvania contracted with IPRO to validate the PIPs that were underway in 2023.

Pennsylvania identifies PIPs by assessing gaps in care with a focus on applying sustainable interventions that will improve the access, quality, or timeliness of care and services provided to the state's Medicaid beneficiaries. DHS-selected topics require that each MCO implement work plans and activities consistent with PIPs, as required by federal and state regulations. The EQRO reviews PIP proposals and PIP reports and provides technical assistance throughout the life of the PIP. PIP project validation activities and results are summarized annually by the EQRO for the state.

To introduce each PIP cycle, DHS provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given regarding expectations for PIP relevance, quality, completeness, resubmissions, and timeliness.

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

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

- activity selection and methodology;
- data/results;
- analysis cycle; and
- interventions.

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

Performance Improvement Project Topics

Strengthening Care Coordination was selected as a topic following discussions with stakeholders and in collaboration with the EQRO. The MCO was required to implement interventions and measure performance

on the topic of strengthening care coordination with assessment and improvement of outcomes of care rendered by the MCO. The initial PIP proposal was submitted in September 2018, ahead of PIP implementation on January 1, 2019. Accordingly, the MCO submitted proposals for PIP expansion into the SE Region in September 2019 and throughout the entirety of PA in September 2020. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly.

Transition of Care from the NF to the Community was selected following discussions with stakeholders and in collaboration with the EQRO. The MCO was required to implement interventions and measure performance on the topic of transition of care from the NF to the community, entailing assessment and improvement of outcomes of care rendered by the MCO. The initial PIP proposal was submitted in September 2018, ahead of PIP implementation on January 1, 2019. Accordingly, the MCO submitted proposals for PIP expansion into the SE Region in September 2019 and throughout the entirety of PA in September 2020. Eligible populations initially included the NFCE participants and expanded accordingly.

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. The MCO is encouraged to continuously assess their rates for performance indicators (PIs) each year and adjust goals accordingly, as goals should be robust, yet attainable.

1. For PIP topic/rationale elements, the following are reviewed: attestation signed and PIP identifiers completed; impacts the maximum feasible proportion of members; potential for meaningful impact on member health, functional status, or satisfaction; reflects high-volume or high-risk conditions; and supported with MCO member data (e.g., historical data related to disease prevalence).

2. For PIP aim, the following are reviewed: aim specifies PIs for improvement, with corresponding goals; goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with rationale (e.g., benchmark); and objectives align aim and goals with interventions.

3. For PIP methodology, the following are reviewed: PIs are clearly defined and measurable (specifying numerator and denominator criteria); PIs are measured consistently over time; PIs measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes; eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined; procedures indicate data source, hybrid vs. administrative, reliability (e.g., inter-rater reliability [IRR]); if sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias, and the sampling technique specifies estimated/true frequency, margin of error, and confidence interval; study design specifies data collection methodologies that are valid, reliable, representative of the entire eligible population, and presented with a corresponding timeline; and study design specifies data analysis procedures with a corresponding timeline.

4. For PIP barrier analysis, the following are reviewed: susceptible subpopulations identified using claims data on PMs, stratified by demographic and clinical characteristics; member input at focus groups and/or quality meetings, and/or from care management (CM) outreach; provider input at focus groups

and/or quality meetings; quality improvement process data ("5 Why's," fishbone diagram); HEDIS rates or other performance metric (e.g., CAHPS); and literature review.

5. For PIP intervention robustness, the following are reviewed: informed by barrier analysis; actions that target member, provider, and MCO; new or enhanced, starting after baseline year; and with corresponding monthly or quarterly intervention tracking measures (also known as process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports).

6. For PIP results, the following is reviewed: table shows PI rates, numerators, and denominators, all with corresponding goals.

7. For discussion and validity of reported improvement in the PIP, the following are reviewed: interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions); data presented adhere to the statistical techniques outlined in the MCO's data analysis plan; analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity; and, lessons learned and follow-up activities planned as a result.

8. For PIP sustainability, the following are reviewed: ongoing, additional, or modified interventions documented; and sustained improvement demonstrated through repeated measurements over comparable time periods.

Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable.

Scoring elements and methodology are used during the intervention and sustainability periods. MY 2018 is the initial baseline year, and during MY 2022, elements were reviewed at multiple points during the year and scored using the Year 4 annual reports submitted in 2023. All MCOs received some level of guidance towards improving their submissions in these findings, and MCOs responded accordingly with resubmissions to correct specific areas. These review findings are included in each MCO's technical report, although MCOs continue to respond and resubmit as applicable to correct specific areas.

The first seven elements in the numbered list above relate to the baseline and demonstrable improvement phases of the project. The eighth element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on Met, Partially Met, and Not Met. Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. The overall score expresses the level of compliance.

Table 1 presents the terminologies used in the scoring process, their respective definitions, and their weight.

Table 1: 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%. Corrective action plans are not warranted for CHC MCOs that are compliant with PIP implementation requirements.

Findings

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 2** (Scoring Matrix), PIPs are also reviewed for the achievement of sustained improvement, which is assessed for the final year of a PIP.

Table 2: 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%**

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.

For the **Strengthening Care Coordination** PIP, MCOs were required to submit rates at the baseline and at the interim PIP years for the following transitions of care measures aligned with clinical care coordination:

- Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission or the following day
- Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge or the following day
- Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

- 7-Day Follow Up After a Behavioral Health Discharge: Percent of discharges for which the member received follow-up within seven days of discharge
- Transitional Care Planning/Notification of Discharge: Admissions with a discharge status for whom: a) Transitional Care Planning Activities or b) Education to the member, caregiver, or health system to notify the CHC MCO of discharge within two (2) business days of discharge, began during the hospital stay

For the **Transition of Care from the NF to the Community** PIP, MCOs were required to submit rates at the baseline and at the interim PIP years for the following measures:

- Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge or the following day.
- Patient Engagement after Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
- Patient Remaining in the Home or Community Post Discharge: The percentage of discharges from a nursing facility (NF) that resulted in the Community HealthChoices (CHC) participant remaining in their home or community for six (6) or more months post-discharge
- Transitional Care Planning: Skilled nursing facility (NF) admissions resulting in discharges for whom transitional care planning began within two business days of notification of NF admission

Conclusions and Comparative Findings

To encourage focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements. The multiple levels of activity and collaboration between the Department, the MCOs, and IPRO continued and progressed throughout the measurement year.

Throughout 2023 there were several levels of communication provided to MCOs after their Year 4 submissions including:

- MCO-specific review findings for each PIP.
- Conference calls with each MCO as needed to discuss the PIP review findings with key MCO staff assigned to each PIP topic.
- Information to assist MCOs such as additional instructions regarding collection of the required PIs and considerations for expanding methodologies.

PIP activities during the year included updating PIP PI goals, baseline rates, barrier analyses, and development and implementation of both interventions and additional PIs. 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 external quality review and scored for reporting the year's PIP compliance determinations, were submitted to IPRO in March 2023. Updates on interventions through the first half of 2023 were submitted to IPRO in July 2023.

The following summarizes PIP compliance assessments for the MCO's Annual PIP Reports (Year 4 implementation) review findings aligned with the determinations presented in **Table 3**. Upon request, the MCO's PIP reports and the EQRO's review findings can be made available for reference. **Table A1** of the MCO's interventions for the PIPs can be found in the **Appendix** of this report.

Strengthening Care Coordination

For the Year 4 implementation review, the MCO scored 100% (80.0 points out of a maximum possible weighted score of 80.0 points).

Several recommendations were made regarding the enhancement of the barrier analysis and results sections of the report. Overall, the MCO generally utilized comparable methodology across regions, which factored available information for continuous improvement over the course of expanding implementation. Moving forward, the MCO plans to incorporate new information and guidelines as the PIP evolves over the course of implementation.

Transition of Care from Nursing Facility to the Community

For the Year 4 implementation review, the MCO scored 100% overall compliance rate (80.0 points out of a maximum possible weighted score of 80.0 points).

Several recommendations were made regarding the goals section of the report. Overall, the MCO generally utilized comparable methodology across regions, which factored available information for continuous improvement over the course of expanding implementation. Moving forward, the MCO plans to incorporate new information and guidelines as the PIP evolves over the course of implementation.

Table 3: PIP Compliance Assessments

Review Element	Strengthening Care Coordination	Transition of Care from Nursing Facility to the Community
Element 1. Project Topic/Rationale	Met	Met
Element 2. Aim	Met	Met
Element 3. Methodology	Met	Met
Element 4. Barrier Analysis	Met	Met
Element 5. Robust Interventions	Met	Met
Element 6. Results Table	Met	Met
Element 7. Discussion and Validity of Reported Improvement	Met	Met

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

III. Validation of Performance Measures

Objectives

Pennsylvania selects quality metrics and performance targets by assessing gaps in care within the state's Medicaid population. DHS monitors and utilizes data that evaluates the MCOs' strengths and opportunities for improvement in serving the Medicaid population by specifying performance measures. The selected performance measures and performance targets are reasonable, based on industry standards, and consistent with the CMS' External Quality Review Protocols. The MCOs are required to follow NCQA HEDIS, CMS Adult Core Set, and PA-specific performance measure technical specifications for reporting. DHS, generally, 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.

Technical Methods of Data Collection and Analysis

The EQRO conducted PM validation for each of the MCOs and facilitated associated data collection.

Technical specifications for the one PAPM, as well as submission instructions, were provided to the MCOs. As part of the process, the EQRO requested submissions of the MCO's materials, including preliminary measure calculations, and internal data and code corresponding to the calculations. Using materials and anecdotal information provided to the EQRO, measure-specific code was run against the data, and the EQRO implemented a stepwise series of tests on key criteria per technical specifications. Following the review, the EQRO provided the MCO with formal written feedback, and the MCO was given the opportunity for resubmission of the materials upon detection of errors, as necessary.

HEDIS MY 2022 measures from the NCQA publication, *HEDIS MY 2022 Volume 2: Technical Specifications*, were validated through a standard HEDIS compliance audit of each MCO. Additionally, LTSS measures and two HEDIS Medicare measures are also required by OLTL. The audit protocol includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of the Interactive Data Submission System (IDSS). Final Audit Reports were submitted to NCQA for the MCOs. Because the PA-specific PMs rely on the same systems and staff, no separate review was necessary for validation of PA-specific measures. The EQRO conducts a thorough review and validation of source code, data, and submitted rates for the PA-specific measures. For the measures from the NCQA publication, *HEDIS 2022 Technical Specifications for Long-Term Services and Supports Measures*, rates were not certified by NCQA; data was collected for informational purposes only for the Department's use.

Description of Data Obtained

Evaluation of MCO performance is HEDIS measures and PA-specific performance measures. A list of the PMs included in this year's EQR report is presented in **Table 4**.

Table 4: Performance Measure Groupings

Source	Measures
Access to/Availability of Care	
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (AAP)
PA EQR	Adult Annual Dental Visit (AADV)
Behavioral Health	
HEDIS	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)
HEDIS	Antidepressant Medication Management (AMM)

Source	Measures
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
HEDIS	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
HEDIS	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
HEDIS	Pharmacotherapy for Opioid Use Disorder (POD)
Cardiovascular Conditions	
HEDIS	Cardiac Rehabilitation (CRE)
HEDIS	Controlling High Blood Pressure (CBP)
HEDIS	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease (SPC)
Care Coordination	
HEDIS	Advance Care Planning (ACP)
HEDIS	Transitions of Care (TRC)
Diabetes	
HEDIS	Blood Pressure Control for Patients With Diabetes (BPD)
HEDIS	Eye Exam for Patients With Diabetes (EED)
HEDIS	Hemoglobin A1c Control for Patients With Diabetes (HBD)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (KED)
HEDIS	Statin Therapy for Patients With Diabetes (SPD)
Electronic Clinical Data Systems	
HEDIS	Adult Immunization Status (AIS-E)
Long-Term Services and Supports	
HEDIS	Long-Term Services and Supports Comprehensive Assessment and Update (CAU)
HEDIS	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU)
HEDIS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (RAC)
HEDIS	Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner (SCP)
Overuse/Appropriateness	
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
HEDIS	Risk of Continued Opioid Use (COU)
HEDIS	Use of Imaging Studies for Low Back Pain (LBP)
HEDIS	Use of Opioids at High Dosage (HDO)
HEDIS	Use of Opioids From Multiple Providers (UOP)
Prevention and Screening	
HEDIS	Breast Cancer Screening (BCS)
HEDIS	Care for Older Adults (COA)
HEDIS	Cervical Cancer Screening (CCS)
HEDIS	Chlamydia Screening in Women (CHL)
Race and Ethnicity	
HEDIS	Controlling High Blood Pressure (CBP)
HEDIS	Hemoglobin A1c Control for Patients With Diabetes (HBD)
Respiratory Conditions	
HEDIS	Asthma Medication Ratio (AMR)
HEDIS	Pharmacotherapy Management of COPD Exacerbation (PCE)
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Source	Measures
Utilization	
HEDIS	Ambulatory Care (AMB)
HEDIS	Antibiotic Utilization for Respiratory Conditions (AXR)
HEDIS	Frequency of Selected Procedures (FSP)
HEDIS	Inpatient Utilization (IPU)
HEDIS	Plan All-Cause Readmissions (PCR)

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

PA Performance Measure Selection and Descriptions

The Adult Annual Dental Visit measure (AADV) is the single PA-specific PM calculated by each MCO and validated by the EQRO. As there was no HEDIS dental measure for the adult population, IPRO worked in collaboration with DHS to develop an adult dental measure. For each indicator, the criteria were generally specified to identify the eligible population product line, age, enrollment, anchor date, and event/diagnosis. Criteria were outlined to identify the administrative numerator positives, date of service, and diagnosis/procedure code, as well as other specifications as needed. PA-specific PM rates were calculated administratively, which uses only the MCOs data systems to identify numerator positives.

HEDIS Performance Measure Selection and Descriptions

MCOs were required to report all applicable measures required by NCQA for accreditation; this included HEDIS measures with Medicaid listed as the product line, excluding measures that are childhood-related and measures requiring a behavioral health benefit. MCOs were required to report in accordance with HEDIS MY 2022 product line technical specifications and to follow the NCQA timeline (notably, on or before June 15, 2023: MCOs were required to submit the auditor-locked IDSS submissions, with attestation, to NCQA). MCOs were instructed to indicate on the Healthcare Organization Questionnaire (HOQ) that the audited HEDIS MY 2022 submissions uploaded for NCQA may be reported publicly by NCQA (e.g., through NCQA's Quality Compass). No measures were rotated from the prior year.

The CHC population was grouped to align with three benefit structures for CHC reporting per NCQA guidelines.

- The first group identified members who were Medicaid-only members with CHC benefits (i.e., those not also enrolled in Medicare).
- The second group identified members with CHC benefits and Medicare benefits with the same MCO, (i.e., Medicare-Medicaid enrolled), or aligned dual eligible special needs plan (D-SNP) and CHC benefits (per NCQA requirements, MCOs that offer Medicaid and Medicare-Medicaid dual benefits include the MCO's aligned dual-eligible members under Medicaid reporting). The Medicaid IDSS submission is comprised of these first two groups. Additionally, there are two measures (Care for Older Adults [COA] and Transitions of Care [TRC]) that must be reported for the second group only; these were captured via submission of a separate, partially completed Medicare IDSS.
- A third group comprised members who have CHC benefits and Medicare benefits with different MCOs (i.e., D-SNP enrollment is not aligned with the MCO, or the member has another Medicare Advantage or fee-for-service plan).

The CHC-MCOs were required to report the LTSS measures and include all three participant groups depicted above.

Benefits were assessed for dually enrolled members for each product in which they were reported.

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. The standardized survey instrument selected for Pennsylvania's Community HealthChoices program was the CAHPS 5.1H Adult Medicaid Health Plan Survey.

As with HEDIS performance measure reporting, CAHPS reporting populations were aligned per NCQA guidelines following the same benefit structures as the HEDIS performance measures. CAHPS sample frames for each of the four CHC-MCO were validated. The set entailed two sampling frames for each CHC-MCO: a Medicaid Adult CAHPS sampling frame (aligned with the Medicaid IDSS) and a Medicaid Adult CAHPS sampling frame for just the second group (i.e unaligned D-SNP, Medicare Advantage, fee for service subpopulation). The MCO's survey sample frame was deemed valid by the NCQA-certified auditor.

Per agreement with the Department: MCOs submitted CAHPS files for Adult Medicaid according to NCQA guidelines specified in the NCQA publication, *HEDIS MY 2022 Volume 3: Specifications for Survey Measures*; in addition, the Adult CAHPS was completed with the inclusions of PA-specific supplemental dental and mental health questions.

Implementation of PA-Specific Performance Measures

The MCO implemented one PA-specific measure (AADV) for MY 2022, which was reported with MCO-submitted data in September 2023. The MCO submitted all required source code and data for review (the EQRO reviewed the source code and validated raw data submitted by the MCO). Rate calculations were collected via rate sheets and reviewed. Final AADV rates were considered reportable.

Conclusions and Comparative Findings

MCO results are presented in **Table 5** through **Table 19**. For each measure, the denominator, numerator, and MY rates with 95% upper and lower confidence intervals (95% CI) are presented. Confidence intervals are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would fall within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.

Rates for both the MY and the previous year are presented, as available (i.e., MY 2022 and MY 2021). In addition, statistical comparisons are made between the MY 2022 and MY 2021 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the *Z* ratio. A *Z* ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s.". For some measures, a lower rate indicates better performance.

In addition to each individual MCO's rate, the CHC-MCO average for MY 2022 and a weighted average are presented. The CHC-MCO mean is a simple average of each MCO's rate whereas the weighted average is an average that considers the proportional relevance of each MCO. The CHC-MCO mean does not include measures with denominators less than 30.

Table 5 to **Table 19** show rates up to one decimal place. Calculations to determine differences between rates are based upon unrounded rates. Due to rounding, differences in rates that are reported in the narrative may differ slightly from the difference between rates presented in the table.

Access to/Availability of Care

No strengths are identified for MY 2022 Access to/Availability of Care performance measure.

Opportunities for improvement are identified for MY 2022 Access to/Availability of Care of Care performance measure.

- Although AADV performed better compared to MY 2021, the rate continues to remain low. Additionally, the MY 2022 rate was statistically significant below the weighted average by 4.6 percentage points. These findings suggest a continued opportunity for improvement for the CHC-MCO.

Table 5 Access to/Availability of Care Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 20 to 44 years)	1,694	1,504	88.8%	87.2%	90.3%	88.2%	n.s.	91.8%	92.0%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 45 to 64 years)	4,639	4,333	93.4%	92.7%	94.1%	93.6%	n.s.	96.3%	96.5%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 65 years and older)	3,157	2,906	92.1%	91.1%	93.0%	91.2%	n.s.	95.4%	96.0%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Total)	9,490	8,743	92.1%	91.6%	92.7%	91.9%	n.s.	95.2%	95.7%
PA EQR	Annual Adult Dental Visit (Age 21 and older)	12,944	76,725	16.9%	16.6%	17.1%	15.1%	+	21.5%	21.5%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."

Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review.

Behavioral Health

There are no strengths identified for MY 2022 Behavioral Health of Care performance measures.

There are no opportunities for improvement identified for MY 2022 Behavioral Health of Care performance measures.

Table 6: Behavioral Health Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	366	262	71.6%	66.8%	76.3%	74.2%	n.s.	76.8%	78.5%
HEDIS	Antidepressant Medication Management - Effective Acute Phase Treatment	445	348	78.2%	74.2%	82.2%	80.9%	n.s.	75.0%	74.9%
HEDIS	Antidepressant Medication Management - Effective Continuation Phase Treatment	445	301	67.6%	63.2%	72.1%	71.5%	n.s.	61.0%	59.7%
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	N/A	N/A	N/A	N/A	N/A	68.0%	N/A	74.4%	75.4%
HEDIS	Diabetes Monitoring for People With Diabetes and Schizophrenia	161	97	60.3%	52.4%	68.1%	61.1%	n.s.	68.9%	72.5%
HEDIS	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	429	339	79.0%	75.0%	83.0%	82.2%	n.s.	84.9%	84.8%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Pharmacotherapy for Opioid Use Disorder (Age 65 years and older)	N/A	N/A	N/A	N/A	N/A	62.5%	N/A	42.1%	42.1%
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 16 to 64 years)	112	44	39.3%	29.8%	48.8%	37.7%	n.s.	33.0%	32.6%
HEDIS	Pharmacotherapy for Opioid Use Disorder (Total)	119	48	40.3%	31.1%	49.6%	42.9%	n.s.	34.3%	34.1%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable, as denominator is less than 30, other results are filtered.

Cardiovascular Conditions

A strength was identified for MY 2022 Cardiovascular Conditions performance measures.

- The Controlling High Blood Pressure measure had a statistically significant increase of 16.6% percentage points when compared to MY 2021.

Opportunities for improvement are identified for MY 2022 Cardiovascular Conditions of Care performance measure.

- Stain Therapy for Patients with Cardiovascular Disease – Received Statin Therapy (Males ages 21 to 75 years) was significantly below the weighted average by 4.9 percentage points.

Table 7: Cardiovascular Conditions Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure	411	276	67.2%	62.5%	71.8%	50.6%	+	71.3%	71.0%
HEDIS	Persistence of Beta-Blocker Treatment After a Heart Attack	N/A	N/A	N/A	N/A	N/A	91.3%	N/A	93.3%	93.8%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Males ages 21 to 75 years)	256	214	83.6%	78.9%	88.3%	83.0%	n.s.	88.6%	88.5%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Females ages 40 to 75 years)	224	189	84.4%	79.4%	89.4%	85.7%	n.s.	86.4%	85.8%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	480	403	84.0%	80.6%	87.3%	84.4%	n.s.	87.4%	87.1%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Males ages 21 to 75 years)	214	183	85.5%	80.6%	90.5%	79.0%	n.s.	83.9%	86.2%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Females ages 40 to 75 years)	189	168	88.9%	84.2%	93.6%	82.8%	n.s.	84.8%	84.9%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	403	351	87.1%	83.7%	90.5%	81.0%	+	84.4%	85.6%
HEDIS	Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Total)	81	1	1.2%	0.0%	4.2%	0.7%	n.s.	2.7%	2.8%
HEDIS	Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Total)	81	2	2.5%	0.0%	6.5%	0.7%	n.s.	4.7%	5.0%
HEDIS	Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	81	4	4.9%	0.4%	10.3%	0.7%	+	5.0%	5.6%
HEDIS	Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	81	2	2.5%	0.0%	6.5%	0.7%	n.s.	1.9%	2.6%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable, as denominator is less than 30, other results are filtered.

Care Coordination

No strengths are identified for MY 2022 Care Coordination performance measure.

Opportunities for improvement are identified for MY 2022 Care Coordination of Care performance measure.

- Despite a statistically significant positive change for the Medication Reconciliation Post Discharge and Notification of Inpatient Admission portions of the Transitions of Care performance measure, when compared to MY 2021, Medication Reconciliation Post Discharge was 24.8 percentage points lower than the weighted average, while Notification of Inpatient Admission was 17.2 percentage points lower than the weighted average. These statistically significant differences point to opportunities for improvement.

Table 8: Care Coordination Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Advance Care Planning	1,524	629	41.3%	38.8%	43.8%	N/A	N/A	29.9%	30.9%
HEDIS	Transitions of Care - Notification of Inpatient Admission (Total)	411	85	20.7%	16.6%	24.7%	11.7%	+	28.7%	37.9%
HEDIS	Transitions of Care - Receipt of Discharge Information (Total)	411	66	16.1%	12.4%	19.7%	9.5%	+	20.7%	28.8%
HEDIS	Transitions of Care - Patient Engagement After Inpatient Discharge (Total)	411	325	79.1%	75.0%	83.1%	80.8%	n.s.	83.8%	86.4%
HEDIS	Transitions of Care - Medication Reconciliation Post-Discharge (Total)	411	185	45.0%	40.1%	49.9%	36.0%	+	64.5%	69.8%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Diabetes

Strengths were identified for MY 2022 Diabetes performance measure.

- Blood Pressure Control for Patients with Diabetes, Eye Exam for Patients with Diabetes, Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8%) and Poor HbA1c Control (>9.0%) all had statistically significant increases in MY 2022 when compared to MY 2021.
- Additionally, Statin Therapy for Patients With Diabetes - Statin Adherence 80% had a statistically significant increase in MY 2022 when compared to MY 2021

Opportunities for improvement are identified for MY 2022 Diabetes of Care performance measure.

- Kidney Health Evaluation for Patients with Diabetes (ages 65 to 74 years) was 11.1 percentage points statistically lower than the weighted average, while Kidney Health Evaluation for Patients with Diabetes (ages 18 to 64 years) was 8.6 percentage points statistically lower than the weighted average. In summary, the Kidney Health Evaluation for Patients with Diabetes (Total) was 8.8 percentage points lower than the weighted average.

Table 9: Diabetes Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Blood Pressure Control for Patients With Diabetes	411	280	68.1%	63.5%	72.8%	50.9%	+	68.1%	68.4%
HEDIS	Eye Exam for Patients With Diabetes	411	246	59.9%	55.0%	64.7%	48.4%	+	63.1%	65.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	411	248	60.3%	55.5%	65.2%	42.3%	+	61.4%	62.8%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control (>9.0%)	411	135	32.9%	28.2%	37.5%	49.6%	-	29.0%	27.1%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 18 to 64 years)	1,746	585	33.5%	31.3%	35.8%	32.9%	n.s.	40.0%	42.1%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 65 to 74 years)	510	209	41.0%	36.6%	45.4%	37.4%	n.s.	49.3%	52.0%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 75 to 85 years)	166	86	51.8%	43.9%	59.7%	42.3%	n.s.	50.5%	51.4%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Total)	2,422	880	36.3%	34.4%	38.3%	34.3%	n.s.	42.7%	45.1%
HEDIS	Statin Therapy for Patients With Diabetes - Received Statin Therapy	1,465	1,133	77.3%	75.2%	79.5%	75.5%	n.s.	78.5%	78.7%
HEDIS	Statin Therapy for Patients With Diabetes - Statin Adherence 80%	1,133	959	84.6%	82.5%	86.8%	79.9%	+	83.5%	83.9%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set;

Electronic Clinical Data Systems

No strengths are identified for MY 2022 Electronic Clinical Data Systems performance measure.

Opportunities are identified for MY 2022 Electronic Clinical Data Systems performance measure.

- Adult Immunization Status – Td/TDaP despite showing improvement compared to MY 2021, was 20.8 percentage points lower than the weighted average.
- Adult Immunization Status – Zoster despite also showing improvement compared to MY 2021, was 10.8 percentage points lower than the weighted average.

Table 10: Electronic Clinical Data Systems Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adult Immunization Status - Influenza (Ages 19 to 65 years)	5,705	931	16.3%	15.3%	17.3%	15.6%	n.s.	32.8%	30.6%
HEDIS	Adult Immunization Status - Td/TDap (Ages 19 to 65 years)	5,705	776	13.6%	12.7%	14.5%	10.1%	+	33.2%	34.4%
HEDIS	Adult Immunization Status - Zoster (Ages 50 to 65 years)	3,608	99	2.7%	2.2%	3.3%	1.5%	+	11.2%	13.5%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Long-Term Services and Supports

Several strengths were identified for MY 2022 Long-Term Services and Supports of Care performance measure.

- Reassessment After Inpatient Discharge was 12.6 percentage points higher than the weighted average and-Reassessment and Care Plan Update After Inpatient Discharge was 18.4 percentage points higher than the weighted average. Both measures reflected rate improvement over MY 2021.

- Shared Care Plan with Primary Care Practitioner was statistically significantly higher by 24 percentage points compared to MY 2021.

No opportunities are identified for MY 2022 Long-Term Services and Supports performance measure

Table 11: Long-Term Services and Supports Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Long-Term Services and Supports Comprehensive Assessment and Update - Assessment of Core Elements	96	83	86.5%	79.1%	93.8%	52.1%	+	92.2%	92.1%
HEDIS	Long-Term Services and Supports Comprehensive Assessment and Update - Assessment of Supplemental Elements	96	83	86.5%	79.1%	93.8%	52.1%	+	91.9%	91.9%
HEDIS	Long-Term Services and Supports Comprehensive Care Plan and Update - Care Plan with Core Elements Documented	96	77	80.2%	71.7%	88.7%	55.2%	+	85.2%	84.6%
HEDIS	Long-Term Services and Supports Comprehensive Care Plan and Update - Assessment of Supplemental Elements	96	77	80.2%	71.7%	88.7%	55.2%	+	85.2%	84.6%
HEDIS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge - Reassessment After Inpatient Discharge	96	59	61.5%	51.2%	71.7%	41.7%	+	46.9%	48.9%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge - Reassessment and Care Plan Update After Inpatient Discharge	96	55	57.3%	46.9%	67.7%	36.5%	+	41.1%	38.9%
HEDIS	Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner	96	67	69.8%	60.1%	79.5%	45.8%	+	67.2%	64.6%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Overuse/Appropriateness

No strengths are identified for MY 2022 Overuse/Appropriateness performance measure.

Opportunities for improvement are identified for MY 2022 Overuse/Appropriateness of Care performance measure.

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis Ages 18 to 64 years and Total saw a decrease in the MY 2022 rates compared to MY 2021. Ages 18 to 64 years rate was 16.1 percentage points lower than the weighted average, while the total rate was 13.5 percentage points lower than the weighted average.
- Overall, the Risk of Continued Opioid Use was statistically significantly higher than the weighted average across both reporting groups and age stratifications, which indicates an opportunity for improvement.

Table 12: Overuse/Appropriateness Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18 to 64 years)	49	32	34.7%	20.3%	49.0%	55.2%	N/A	48.3%	50.8%
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65 years and older)	N/A	N/A	N/A	N/A	N/A	33.3%	N/A	38.2%	37.4%
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	67	45	32.8%	20.9%	44.8%	51.4%	n.s.	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)	856	189	22.1%	19.2%	24.9%	22.1%	n.s.	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)	235	82	34.9%	28.6%	41.2%	28.6%	n.s.	19.6%	17.8%
HEDIS	Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Total)	1,091	271	24.8%	22.2%	27.4%	23.5%	n.s.	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)	856	151	17.6%	15.0%	20.2%	19.1%	n.s.	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)	235	58	24.7%	18.9%	30.4%	24.2%	n.s.	12.8%	10.7%
HEDIS	Risk of Continued Opioid Use - At Least 31 Days of Prescription Opioids in a 62-day Period (Total)	1,091	209	19.2%	16.8%	21.5%	20.2%	n.s.	10.7%	10.1%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Use of Imaging Studies for Low Back Pain (Total)	217	47	78.3%	72.6%	84.0%	71.7%	n.s.	77.2%	77.2%
HEDIS	Use of Opioids at High Dosage	796	102	12.8%	10.4%	15.2%	11.6%	n.s.	11.5%	10.0%
HEDIS	Use of Opioids From Multiple Providers - Multiple Pharmacies	1,041	10	1.0%	0.3%	1.6%	0.9%	n.s.	1.4%	1.9%
HEDIS	Use of Opioids From Multiple Providers - Multiple Prescribers	1,041	168	16.1%	13.9%	18.4%	12.6%	+	15.9%	17.0%
HEDIS	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	1,041	5	0.5%	0.0%	0.9%	0.4%	n.s.	0.6%	1.1%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; N/A: Not Available, as in denominator is less than 30, other related results are filtered.

Prevention and Screening

Strengths are identified for MY 2022 Prevention and Screening performance measure.

- Care for Older Adults – Medication Review improved significantly by 5.9 percentage points when compared to the MY 2021 rate.
- Care for Older Adults – Pain Assessment improved significantly by 20.2 percentage points when compared to the MY 2021 rate.

Opportunities for improvement are identified for MY 2022 Prevention and Screening of Care performance measure.

- Breast Cancer Screening was 14.2 percentage points below the weighted average.
- Care for Older Adults - Functional Status Assessment was 6.3 percentage points below the weighted average.
- Cervical Cancer Screening was 11.9 percentage points below the weighted average, despite showing a statistically significant improvement from MY 2021.

Table 13: Prevention and Screening Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Breast Cancer Screening	2,258	1,081	47.9%	45.8%	50.0%	44.8%	n.s.	58.3%	62.1%
HEDIS	Care for Older Adults - Functional Status Assessment	411	250	60.8%	56.0%	65.7%	57.2%	n.s.	62.2%	67.1%
HEDIS	Care for Older Adults - Medication Review	411	389	94.7%	92.3%	97.0%	88.8%	+	95.9%	93.1%
HEDIS	Care for Older Adults - Pain Assessment	411	356	86.6%	83.2%	90.0%	66.4%	+	88.6%	87.4%
HEDIS	Cervical Cancer Screening	411	166	40.4%	35.5%	45.3%	31.1%	+	49.5%	52.3%
HEDIS	Chlamydia Screening in Women (Ages 21 to 24 years)	N/A	N/A	N/A	N/A	N/A	50.0%	N/A	44.7%	44.5%
HEDIS	Chlamydia Screening in Women (Total)	N/A	N/A	N/A	N/A	N/A	50.0%	N/A	44.7%	44.5%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; DHS: Department of Human Services; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; N/A: Not Available, as in denominator is less than 30, other related results are filtered.

Race and Ethnicity

No strengths are identified for MY 2022 Race and Ethnicity of Care performance measure

Opportunities for improvement are identified for MY 2022 Race and Ethnicity of Care performance measure

- Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: White (Direct) was 11.3 percentage points lower than the weighted average indicating an opportunity for improvement.
- Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: White (Total) was 12.7 percentage points higher than the weighted average, as this part of the measure is inverse, this is identified as an opportunity for improvement.

Table 14: Race and Ethnicity Stratification

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure - Ethnicity: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HEDIS	Controlling High Blood Pressure - Ethnicity: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HEDIS	Controlling High Blood Pressure - Ethnicity: Hispanic or Latino (Direct)	50	31	62.0%	47.5%	76.5%	N/A	N/A	70.9%	72.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Hispanic or Latino (Total)	50	31	62.0%	47.5%	76.5%	N/A	N/A	70.9%	72.8%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure - Ethnicity: Not Hispanic or Latino (Direct)	361	245	67.9%	62.9%	72.8%	N/A	N/A	71.1%	70.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Not Hispanic or Latino (Total)	361	245	67.9%	62.9%	72.8%	N/A	N/A	71.1%	70.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	73.3%	68.3%
HEDIS	Controlling High Blood Pressure - Race: American Indian and Alaska Native (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75.0%	75.0%
HEDIS	Controlling High Blood Pressure - Race: American Indian and Alaska Native (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75.0%	75.0%
HEDIS	Controlling High Blood Pressure - Race: Asian (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	73.6%	72.9%
HEDIS	Controlling High Blood Pressure - Race: Asian (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	73.6%	72.9%
HEDIS	Controlling High Blood Pressure - Race: Asked but No Answer (Direct)	45	29	64.4%	49.3%	79.5%	N/A	N/A	76.1%	76.8%
HEDIS	Controlling High Blood Pressure - Race: Asked but No Answer (Total)	45	29	64.4%	49.3%	79.5%	N/A	N/A	76.1%	76.8%
HEDIS	Controlling High Blood Pressure - Race: Black or African American (Direct)	180	114	63.3%	56.0%	70.6%	N/A	N/A	65.7%	63.4%
HEDIS	Controlling High Blood Pressure - Race: Black or African American (Total)	180	114	63.3%	56.0%	70.6%	N/A	N/A	65.7%	63.4%
HEDIS	Controlling High Blood Pressure - Race: Native Hawaiian and Other Pacific Islander (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
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	N/A	N/A	N/A
HEDIS	Controlling High Blood Pressure - Race: Some Other Race (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100.0%	100.0%
HEDIS	Controlling High Blood Pressure - Race: Some Other Race (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100.0%	100.0%
HEDIS	Controlling High Blood Pressure - Race: Two or More Races (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	65.0%	65.0%
HEDIS	Controlling High Blood Pressure - Race: Two or More Races (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	65.0%	65.0%
HEDIS	Controlling High Blood Pressure - Race: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	81.8%	57.8%
HEDIS	Controlling High Blood Pressure - Race: White (Direct)	171	122	71.4%	64.3%	78.4%	N/A	N/A	73.7%	75.6%
HEDIS	Controlling High Blood Pressure - Race: White (Total)	171	122	71.4%	64.3%	78.4%	N/A	N/A	73.7%	75.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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	N/A	N/A	N/A
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Hispanic or Latino (Direct)	52	31	59.6%	45.3%	73.9%	N/A	N/A	53.8%	55.5%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Hispanic or Latino (Total)	52	31	59.6%	45.3%	73.9%	N/A	N/A	53.8%	55.5%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Not Hispanic or Latino (Direct)	359	217	60.5%	55.3%	65.6%	N/A	N/A	62.1%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Not Hispanic or Latino (Total)	359	217	60.5%	55.3%	65.6%	N/A	N/A	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	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 (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100.0%	100.0%
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	N/A	N/A	N/A	100.0%	100.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asian (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	70.6%	71.8%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asian (Total)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	70.6%	71.8%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asked but No Answer (Direct)	41	24	58.5%	42.2%	74.8%	N/A	N/A	55.8%	55.4%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asked but No Answer (Total)	41	24	58.5%	42.2%	74.8%	N/A	N/A	55.8%	55.4%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Black or African American (Direct)	182	118	64.8%	57.6%	72.1%	N/A	N/A	58.2%	60.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Black or African American (Total)	182	118	64.8%	57.6%	72.1%	N/A	N/A	58.2%	60.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Two or More Races (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	76.9%	76.9%
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	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	N/A	N/A	N/A	62.6%	42.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: White (Direct)	167	88	52.7%	44.8%	60.6%	N/A	N/A	61.3%	64.0%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: White (Total)	167	88	52.7%	44.8%	60.6%	N/A	N/A	61.3%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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	N/A	N/A	N/A
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Hispanic or Latino (Direct)	52	15	28.9%	15.6%	42.1%	N/A	N/A	30.2%	29.2%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Hispanic or Latino (Total)	52	15	28.9%	15.6%	42.1%	N/A	N/A	30.2%	29.2%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Not Hispanic or Latino (Direct)	359	120	33.4%	28.4%	38.4%	N/A	N/A	29.0%	26.7%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Not Hispanic or Latino (Total)	359	120	33.4%	28.4%	38.4%	N/A	N/A	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	N/A	N/A	N/A	34.7%	41.1%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: American Indian and Alaska Native (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%	0.0%
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	N/A	N/A	N/A	0.0%	0.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asian (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	16.4%	15.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asian (Total)	N/A	N/A	N/A	N/A	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 (Direct)	41	11	26.8%	12.0%	41.6%	N/A	N/A	26.0%	25.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asked but No Answer (Total)	41	11	26.8%	12.0%	41.6%	N/A	N/A	26.0%	25.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Black or African American (Direct)	182	58	31.9%	24.8%	38.9%	N/A	N/A	34.4%	32.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Black or African American (Total)	182	58	31.9%	24.8%	38.9%	N/A	N/A	34.4%	32.3%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Two or More Races (Direct)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	19.2%	19.2%
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	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	N/A	N/A	N/A	29.0%	18.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: White (Direct)	167	63	37.7%	30.1%	45.4%	N/A	N/A	28.9%	25.0%

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; N/A: Not Available, as in denominator is less than 30, other related results are filtered.

Respiratory Conditions

No strengths are identified for MY 2022 Respiratory Conditions performance measure

No opportunities are identified for MY 2022 Respiratory Conditions performance measure

Table 15: Respiratory Conditions Performance Measures

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Asthma Medication Ratio (Ages 19 to 50 years)	117	73	62.4%	53.2%	71.6%	63.7%	n.s.	66.2%	65.4%
HEDIS	Asthma Medication Ratio (Ages 51 to 64 years)	138	73	52.9%	44.2%	61.6%	49.0%	n.s.	58.7%	56.1%
HEDIS	Asthma Medication Ratio (Total)	255	146	57.3%	51.0%	63.5%	54.4%	n.s.	61.6%	59.7%
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	287	257	89.6%	85.8%	93.3%	91.3%	n.s.	90.9%	90.9%
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	287	223	77.7%	72.7%	82.7%	73.0%	n.s.	77.8%	78.8%
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	247	50	20.2%	15.0%	25.5%	15.8%	n.s.	21.3%	19.5%

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Utilization

No strengths or opportunities are identified for MY 2022 Utilization performance measure

Table 16: Utilization – Ambulatory Care/Inpatient Utilization

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2021 Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Ambulatory Care - Emergency Dept Visits/1000 Member Years (Total)	124,781	9,931	955.0	917.5	998.6	984.1
HEDIS	Ambulatory Care - Outpatient Visits/1000 Member Years (Total)	124,781	145,654	14,007.3	9,149.8	12,397.0	12,338.3
HEDIS	Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1000 Member Years (Total)[1]	124,781	3,783	364.0	376.8	366.5	365.8

Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Utilization – Antibiotics for Respiratory Conditions

No strengths or opportunities are identified for MY 2022 Utilization – Antibiotics for Respiratory Conditions performance measure.

Table 17: Utilization – Antibiotics for Respiratory Conditions

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate[1]	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Antibiotic Utilization for Respiratory Conditions (Total)	4,140	509	12.3%	11.3%	13.3%	N/A	N/A	13.0%

[1]Antibiotic Utilization for Respiratory Conditions is a first-year measure where a prior year comparison is not available, indicated by "N/A".

Utilization – Antibiotics for Respiratory Conditions

No strengths or opportunities

Table 18: Utilization – Frequency of Selected Procedures (FSP)

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Back Surgery (Females ages 20 to 44 years)	11,439	2	2.1	1.8	2.4	4.3	-	3.3
HEDIS	Frequency of Selected Procedures - Back Surgery (Females ages 45 to 64 years)	34,682	22	7.6	7.3	7.9	5.9	+	8.2
HEDIS	Frequency of Selected Procedures - Back Surgery (Males ages 20 to 44 years)	11,517	1	1.0	0.9	1.2	5.4	-	3.3
HEDIS	Frequency of Selected Procedures - Back Surgery (Males ages 45 to 64 years)	28,433	11	4.6	4.4	4.9	8.4	-	7.2
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 20 to 44 years)	11,439	8	8.4	7.9	8.9	2.2	+	6.5
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 45 to 64 years)	34,682	6	2.1	1.9	2.2	2.3	-	3.3
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 20 and 44 years)	11,517	0	0.0	0.0	0.0	1.1	-	1.8

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 45 to 64 years)	28,433	1	0.4	0.3	0.5	0.0	+	1.1
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 15 to 44 years)	11,439	3	3.1	2.8	3.5	7.7	-	5.6
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 45 to 64 years)	34,682	16	5.5	5.3	5.8	4.0	+	5.3
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Males ages 30 to 64 years)	37,475	15	4.8	4.6	5.0	2.9	+	3.9
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Females ages 15 to 44 years)	11,439	1	1.1	0.9	1.2	0.0	+	0.5
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Females ages 45 to 64 years)	34,682	0	0.0	0.0	0.0	0.6	-	0.8
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Males ages 30 to 64 years)	37,475	3	1.0	0.9	1.1	0.4	+	0.7
HEDIS	Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 15 to 44 years)	11,439	1	1.1	0.9	1.2	1.1	-	1.0
HEDIS	Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 45 to 64 years)	34,682	5	1.7	1.6	1.9	0.6	+	1.2

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 15 to 44 years)	11,439	3	3.1	2.8	3.5	1.1	+	2.3
HEDIS	Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 45 to 64 years)	34,682	0	0.0	0.0	0.0	1.0	-	0.6
HEDIS	Frequency of Selected Procedures - Lumpectomy (Females ages 15 to 44 years)	11,439	1	1.1	0.9	1.2	0.0	+	2.0
HEDIS	Frequency of Selected Procedures - Lumpectomy (Females ages 45 to 64 years)	34,682	9	3.1	2.9	3.3	3.6	-	3.5
HEDIS	Frequency of Selected Procedures - Mastectomy (Females ages 15 to 44 years)	11,439	0	0.0	0.0	0.0	N/A	N/A	0.6
HEDIS	Frequency of Selected Procedures - Mastectomy (Females ages 45 to 64 years)	34,682	6	2.1	1.9	2.2	0.6	+	1.2

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: Not Available, as in rate was 0.0% in MY 2021, other related results are filtered.

Utilization – Plan All-Cause Readmissions (PCR)

No strengths or opportunities are identified for MY 2022 Utilization – Plan All-Cause Readmissions performance measure.

Table 19: Utilization – Plan All-Cause Readmissions (PCR)

Indicator Source	Indicator Name	PHW MY 2022	PHW MY 2021
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Count of Index Stays	181	296
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Count of Index Stays	208	372
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Count of Index Stays	437	860
HEDIS	Plan All-Cause Readmissions (Ages Total) - Count of Index Stays	826	1,528
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Observed 30 - Day Readmission	24	39
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Observed 30 - Day Readmission	31	58
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Observed 30 - Day Readmission	54	110
HEDIS	Plan All-Cause Readmissions (Ages Total) - Observed 30 - Day Readmission	109	207
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Expected 30 - Day Readmission	21	35
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Expected 30 - Day Readmission	31	49
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Expected 30 - Day Readmission	63	125
HEDIS	Plan All-Cause Readmissions (Ages Total) - Expected 30 - Day Readmissions	116	209
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Observed Readmission Rate	13.3	13.2
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Observed Readmission Rate	14.9	15.6
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Observed Readmission Rate	12.4	12.8
HEDIS	Plan All-Cause Readmissions (Ages Total) - Observed Readmission Rate	13.2	13.6
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Expected Readmission Rate	12.1	11.9
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Expected Readmission Rate	15.0	13.1
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Expected Readmission Rate	14.5	14.5

Indicator Source	Indicator Name	PHW MY 2022	PHW MY 2021
HEDIS	Plan All-Cause Readmissions (Ages Total) - Expected Readmission Rate	14.1	13.7
HEDIS	Plan All-Cause Readmissions (Ages Total) – Observed to Expected Readmission Ratio	0.9	1.0

HEDIS: Healthcare Effectiveness Data and Information Set; MY: Measurement Year

CAHPS Health Plan MY 2022 Adult Survey Results

Table 20 provides the survey results of the CAHPS Adult survey 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 populations. 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 20: CHC-MCO CAHPS Health Plan MY 2022 Adult Survey Results

CAHPS Measure	PHW - Aligned	PHW - Unaligned
Your Health Plan		
Satisfaction with Adult's Health Plan (Rating of 8–10)	78.78%	86.49%
Customer Service (Usually or Always)	89.86%	91.75%
Your Access to Care in Last 12 Months		
Getting Needed Care Composite (Usually or Always)	84.10%	86.86%
Getting Care Quickly Composite (Usually or Always)	86.74%	87.21%
Your Personal Doctor		
Satisfaction with Personal Doctor (Rating of 8-10)	85.17%	87.74%
Doctor Informed/Up to Date on Care (Usually or Always)	89.27%	92.89%
How Well Doctors Communicate Composite (Usually or Always)	94.15%	95.21%
Hard to Find Doctor Who Speaks Your Language (Never or Sometimes)	55.43%	49.41%
Hard to Find Doctor Who Understands Your Culture (Never or Sometimes)	65.96%	78.05%

IV. Review of Compliance with Medicaid Managed Care Regulations

Objectives

This section of the EQR report presents a review of the MCO's compliance with its contract and with state and federal regulations. The review is based on information derived from reviews of the 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 Systematic Monitoring, Access and Retrieval Technology (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 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, MCOs provide documents to the Department for review, which address various areas of compliance. This documentation is also used to assess the 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 MCOs.

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. If an MCO does not address a compliance issue, the Department 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 in a formal letter sent by email to the MCO.

Technical Methods of Data Collection and Analysis

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. Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by DHS. 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 non-Compliant, the MCO was evaluated as partially Compliant. If all items were non-Compliant, the MCO was evaluated as non-Compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined was assigned for that category.

Categories determined to be partially compliant or non-compliant are indicated where applicable in the tables below. SMART items, within the categories, that were assigned a value of non-Compliant by DHS are noted. In addition to this analysis of DHS's monitoring of MCO compliance with managed care regulations, IPRO reviewed and evaluated the most recent NCQA accreditation report for each MCO. IPRO accessed the NCQA

Health Plan Reports website[4] to review the *Health Plan Report Cards 2022* for PHW. For each MCO, star ratings, accreditation status, plan type, and distinctions were displayed. At the MCO-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall.

Format

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 and described in the CMS EQR Protocol: *Review of Compliance with Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Regulations*. Under each subpart heading falls the individual regulatory categories appropriate to those headings. Findings will be further discussed relative to applicable subparts as indicated in the updated Protocol, i.e., Subpart D – MCO, PIHP and PAHP Standards and Subpart E – Quality Measurement and Improvement.

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

Description of Data Obtained

The documents used by the EQRO for the current review include the SMART database findings, as of the effective measurement year, per the following: the CHC Agreement, additional monitoring activities outlined by the Department, and the most recent NCQA Accreditation Survey for PHW. 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. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 85 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations.

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.

Table 21 includes all regulations and standards from MY 2022 and related CFR reference citation.

[4] NCQA *Health Plan Report Cards* Website: https://reportcards.ncqa.org/health-plans. Accessed December 19, 2022.

Table 21: Regulations Directly Crosswalked to SMART

BBA Regulation	CFR Citation
Subpart B: State Responsibilities	
Disenrollment	438.56
Subpart C: Enrollee Rights and Protections	
Enrollee Rights	438.100
Emergency and Poststabilization Services	438.114
Subpart D: MCO, PIHP and PAHP Standards	
Availability of Services	438.206
Assurances of adequate capacity and services	438.207
Coordination and continuity of care	438.208
Coverage and authorization of services	438.210
Provider selection	438.214
Confidentiality	438.224
Grievance and appeals systems	438.288
Subcontractual relationships and delegation	438.230
Practice guidelines	438.236
Health information systems	438.242
Subpart E: Quality Measurement and Improvement	
Quality assessment and performance improvement program	438.330

Determination of Compliance

As mentioned above, historically 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 the MCO's compliance status regarding 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 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 non-compliant, the MCO was evaluated as partially compliant. If all items were non-compliant, the MCO was evaluated as non-compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of not determined was assigned for that category.

Categories determined to be partially compliant are indicated where applicable in the tables below, and the SMART items that were assigned a value of non-compliant by the Department within those categories are noted. For PHW, there was one category determined to be partially compliant, signified by one SMART item assigned a value of non-compliant by the Department.

Conclusions and Comparative Findings

Table 22: MCO Compliance with CFR Categories for Subparts B, C, D, and E Directly Associated with SMART

MCO Compliance with CFR Categories for Subparts B, C, D, and E		
State Responsibilities		
Subpart B: Categories	**Compliance**	**Comments**
Disenrollment	Compliant	The MCO was evaluated against 1 item directly associated with this category for 2023 and was complaint on this item based on 2023.
Enrollee Rights and Protections		
Subpart C: Categories	**Compliance**	**Comments**
Enrollee Rights	Compliant	The MCO was evaluated against 6 items directly associated with this category for 2023 and was compliant on all 6 items based on 2023.
Emergency and Poststabilization Services	Compliant	The MCO was evaluated against 3 items directly associated with this category for 2023 and was compliant on all 3 items based on 2023.
MCO, PIHP and PAHP Standards		
Subpart D: Categories	**Compliance**	**Comments**
Availability of services	Compliant	The MCO was evaluated against 5 items directly associated with this category for 2023 and was compliant on all 5 items based on 2023.
Assurances of adequate capacity & services	Compliant	The MCO was evaluated against 5 items directly associated with this category for 2023 and was compliant on all 5 items based on 2023.
Coordination & continuity of care	Partially Compliant	The MCO was evaluated against 25 items directly associated with this category for 2023 and was compliant on 24 items based on 2023.
Coverage & authorization of services	Compliant	The MCO was evaluated against 7 items directly associated with this category for 2023 and was compliant on all 7 items based on 2023.
Provider selection	Compliant	The MCO was evaluated against 3 items directly associated with this category for 2023 and was compliant on all 3 items based on 2023.
Confidentiality	Compliant	The MCO was evaluated against 3 items directly associated with this category for 2023 and was compliant on all 3 items based on 2023.
Grievance and appeals systems	Compliant	The MCO was evaluated against 1 item directly associated with this category for 2023 and was compliant on this item based on 2023.
Subcontractual relationships & delegation	Compliant	The MCO was evaluated against 1 item directly associated with this category for 2023 and was compliant on this item based on 2023.
Practice guidelines	Compliant	The MCO was evaluated against 1 item directly associated with this category for 2023 and was compliant on this item based on 2023.
Health information systems	Compliant	The MCO was evaluated against 8 items directly associated with this category for 2023 and was compliant on all 8 items based on 2023.
Quality Measurement and Improvement		
Subpart E: Categories	**Compliance**	**Comments**
Quality assessment & performance improvement program (QAPI)	Compliant	The MCO was evaluated against 9 items directly associated with this category for 2023 and was compliant on all 9 items based on 2023.

Summarily, the MCO was 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 RY 2022. The MCO had one substandard that was determined to be partially compliant directly associated with CFR Categories for Subpart D.

As it relates to the partially compliant CFR Subpart D, the recommendation is for the MCO 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.

V. Validation of Network Adequacy

Objectives

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. At a minimum, states must develop time and distance 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 dentists, and long-term services and support (LTSS), per *Title 42 CFR § 438.68(b)*. Pennsylvania DHS has developed access standards based on the requirements outlined in *Title 42 CFR § 438.68(c)*. These access standards are described in the Community HealthChoices Agreement, Exhibit T.

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, Pennsylvania contracted with IPRO to perform the validation of network adequacy for Pennsylvania MCOs. In February 2023, CMS released updates to the EQR protocols, including the newly developed network adequacy validation protocol. The protocol six activities related to planning, analysis, and reporting, as outlined in **Table 23.**

Table 23: Network Adequacy Validation Activities

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 2023.

Starting February 2024, the EQRO must conduct validation activities and report those results in the ATR published in April 2025. While validation activities and reporting were not mandatory for 2023, Pennsylvania identified activities 1 and 2 as valuable sources of information to highlight the strengths and opportunities of Pennsylvania's network adequacy standards, indicators, and data collection processes. Additionally, engaging in steps 1 and 2 for 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 Pennsylvania to conduct preliminary network adequacy validation activities using worksheets 4.1, 4.2, and 4.3 of the 2023 CMS EQR protocols. The worksheets identified clear definitions for each network adequacy standard. Future work on Network Adequacy will require identification of indicators and data sources for validation, as well as reviewing information systems, and validating network adequacy.

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 Pennsylvania-established access, distance, and time standards are presented by the two Pennsylvania geographical regions: urban and rural. **Table 24** displays the Pennsylvania Community HealthChoices provider network standards that were applicable in 2023.

Table 24: Network Adequacy Standards, Indicators, and Data Sources

Pennsylvania Network Access Standards	Applicable Provider Types
Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban). This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.	Primary Care Providers
Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than sixty (60) minutes (Rural). This travel time is measured via public transportation, where available.	Primary Care Providers
Ensure a choice of two (2) providers who are accepting new patients within 30 minutes (urban). This travel time is measured via public transportation, where available.	General Surgery Orthopedic Surgery, Ophthalmology Allergy and Immunology, Anesthesiology, Otolaryngology, Neurological Surgery, Neurology, Urology, Cardiology, Dermatology, Gastroenterology, Oral Surgery, Podiatry, Common Laboratory and Diagnostic Service, Obstetrical and Gynecological Service, Physical Medicine and Rehabilitation,
Ensure a choice of two (2) providers who are accepting new patients within 60 minutes (rural). This travel time is measured via public transportation, where available.	General Surgery Orthopedic Surgery, Ophthalmology Allergy and Immunology, Anesthesiology, Otolaryngology, Neurological Surgery, Neurology, Urology, Cardiology, Dermatology, Gastroenterology, Oral Surgery, Podiatry, Common Laboratory and Diagnostic Service, Obstetrical and Gynecological Service, Physical Medicine and Rehabilitation,
Ensure a choice of one (1) provider who is accepting new patients within 60 minutes (urban) and a second choice within the Community HealthChoices Zone.	Endocrinologist, Hematology/Oncology, Rheumatology, Nephrology, Speech Therapy

Pennsylvania Network Access Standards	Applicable Provider Types
Ensure a choice of one (1) provider who is accepting new patients within 60 minutes (rural) and a second choice within the Community HealthChoices Zone.	Endocrinologist, Hematology/Oncology, Rheumatology, Nephrology, Speech Therapy
All Other Provider Types must meet the Participants needs through in-network or out-of-network arrangements. CHC-MCOs should make all reasonable efforts to offer two (2) or more Specialty Providers.	All other specialists and subspecialists not previously identified.
Ensure at least one (1) hospital within 60 minutes (rural) and a second choice within the Community HealthChoices Zone. This travel time is measured via public transportation, where available.	Hospitals
Ensure at least one (1) hospital within 30 minutes (urban) and a second choice within the Community HealthChoices Zone. This travel time is measured via public transportation, where available.	Hospitals
For services where the Participant is traveling to the Provider, the CHC-MCO must ensure a choice of two (2) Providers who are accepting new clients within the travel time limits (thirty (30) minutes Urban). This travel time is measured via public transportation, where available.	LTSS
For services where the Participant is traveling to the Provider, the CHC-MCO must ensure a choice of two (2) Providers who are accepting new clients within the travel time limits (sixty (60) minutes Rural). This travel time is measured via public transportation, where available.	LTSS
LTSS network adequacy requirements are based on the full-time equivalent (FTE) calculations developed by the Department for services where the Provider is traveling to the Participant. FTE network adequacy data must be submitted by CHC zone.	LTSS
For Participants needing anesthesia for dental care, the CHC-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay Out-of-Network.	Dental
Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this Community HealthChoices zone.	Rehabilitation facilities
The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services, provided FQHC and RHC services are available, within a travel time of thirty (30) minutes (Urban) . If the CHC-MCO's Primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC- MCO must demonstrate in writing it has attempted to reasonably contract in good faith.	Federally Qualified Health Centers
The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services, provided FQHC and RHC services are available, within a travel time of sixty (60) minutes (Rural). If the CHC-MCO's Primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC- MCO must demonstrate in writing it has attempted to reasonably contract in good faith.	Federally Qualified Health Centers
Emergency Medical condition cases must be immediately seen or referred to an emergency facility.	Primary Care Providers
Urgent Medical Condition cases must be scheduled within twenty- four (24) hours.	Primary Care Providers

Pennsylvania Network Access Standards	Applicable Provider Types
Non-Urgent Sick Visits must be scheduled with a PCP within seventy-two (72) hours of request, as clinically indicated.	Primary Care Providers
Routine appointments must be scheduled within ten (10) business days. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.	Primary care providers
Emergency Medical Condition appointments immediately upon referral.	Specialist
Urgent Medical Condition care appointments within twenty-four (24) hours of referral.	Specialist
Scheduling of appointments for routine care shall be scheduled to occur within thirty (30) days for all specialty Provider types.	Specialist

VI. 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 QI made by the EQRO during the previous year's EQR." **Table 25** displays the MCO's opportunities as well as IPRO's assessment of their responses. In addition to the opportunities identified from the EQR, DHS also required MCOs to develop a root cause analysis around select P4P indicators.

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each CHC MCO has addressed the opportunities for improvement made by IPRO in the 2022 EQR Technical Reports, which were distributed May 2023.

PHW Response to Previous EQR Recommendations

Table 25 displays PHW's progress related to the *2022 External Quality Review Report,* as well as IPRO's assessment of PHW's response.

Table 25: 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.	Partially addressed. Improvement was observed but several HEDIS performance measures are identified as opportunities for the current year.
It was recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Partially addressed, but identified as an opportunity for the current year. Despite efforts to improve the rate, the Adult Annual Dental Visit measure continues to have low-rate performance.
Compliance with Medicaid Managed Care Regulations	
There were no recommendations related to compliance with CFR Categories for Subparts D and E.	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.
MCO: managed care organization.

VII. MCO Strengths and Opportunities for Improvement, and EQR Recommendations

Table 26 highlights the MCO's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of state fiscal year MY 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

PHW Strengths and Opportunities for Improvement and EQR Recommendations

Table 26: PHW Strengths and Opportunities for Improvement, and EQR Recommendations

EQR Activity		Quality	Timeliness	Access
Strengths				
PIPs	The MCO scored 100% compliance on both the clinical and non-clinical PIPs for the current RY.	✓	-	-
Performance Measures and CAHPS	The MCO had strengths in performance measure areas: Behavioral Health and Long-Term Services and Supports.	✓	✓	✓
Compliance with Medicaid Managed Care Regulations	The MCO was 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 RY 2022.	✓	✓	✓
Opportunities				
PIPs	There are no opportunities related to PIPs for the current RY.	-	-	-
Performance Measures and CAHPS	The MCO had opportunities for improvement in performance measure areas: Access to/Availability of Care, Behavioral Health, Cardiovascular Conditions, Care Coordination, Diabetes, Overuse/Appropriateness, and Prevention and Screening.	✓	✓	✓
Compliance with Medicaid Managed Care Regulations	The MCO was partially compliant with regards to CFR Category Subpart D §438.208 Coordination and continuity of care.	✓	✓	✓
Recommendations				
PIPs	There are no recommendations related to the PIP submissions for the current RY.	-	-	-
Performance Measures and CAHPS	The MCO should improve their rates across several HEDIS performance measures domains.	✓	✓	✓
Compliance with Medicaid Managed Care Regulations	The MCO should improve the transfer of information and records to ensure a seamless transition for participants switching CHC-MCOs.	-	✓	✓

EQR: external quality review; PIP: performance improvement project; RY: report year; NCQA: National Committee for Quality Assurance.

P4P Measure Matrix Report Card MY 2022

The Pay-for-Performance (P4P) Matrix Report Card provides a comparative look at all measures in the CHC-MCO "Community HealthChoices MCO Pay for Performance Program." The matrix:

1. Compares the MCO's MY 2022 P4P measure rates to MY 2022 benchmark goal set by PA; and
2. Compares the managed care organization's (MCO's) own P4P measure performance over the two most recent reporting years, MY 2022 and MY 2021.

There are seven measures: four are HEDIS® measures, two are CAHPS scores, and one is a PA-defined performance indicator. **Table 27** displays the performance indicator descriptions and benchmark goals.

Table 27: MY 2022 P4P Indicators

Indicator Source	Indicator Description	Benchmark Rate
HEDIS	Comprehensive Assessment and Update (CAU)	78.0%
HEDIS	Comprehensive Care Plan Update (CPU)	78.0%
HEDIS	Reassessment and Care Plan Update After Inpatient Discharge (RAC)	38.0%
HEDIS	Share Care Plan with Primary Care Practitioner (SCP)	55.0%
CAHPS – Health Plan Survey	Overall Satisfaction with Health Plan (aligned SNP/Medicaid only population)	83.0%
CAHPS – Home and Community-Based Services Survey	Person-Centered Services Plan (PCSP) Included All Things Important to You	70.0%
Pennsylvania-Defined Performance Indicator	Number of participants successfully transitioned from the NF to the community and remained there for at least six months.	380 per MCO, per year

SNP: special needs plan; NF: nursing facility; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

Figure 1 displays the matrix comparisons for MY 2022. The horizontal comparison represents the MCO's current performance as compared to the MY 2022 benchmark goal. The vertical comparison represents the MCO's performance for each measure in relation to its prior year's rates for the same measure. The MCO's rate can trend up (⇧), have no change (less than 0.5 percentage point improvement), or trend down (⇩). The color codes in the matrix represent degrees of goal attainment.

The green box (A) indicates that performance is optimal. Both P4P goals were met. The MCO's MY 2022 performance indicator(s) are above/better than the MY 2022 performance benchmark and are above/better than MY 2021 by greater than or equal to 3 percentage points.

The light green boxes (B) indicate that performance is notable.

- Either the MCO's MY 2022 performance indicator(s) are above/better than the MY 2022 performance benchmark and are above/better than MY 2021 by greater than or equal to 0.5 percentage points but less than 3 percentage points; or
- the MCO's MY 2022 performance indicator(s) are below/worse than the MY 2022 performance benchmark but improved in MY 2022 compared to MY 2021 by greater than 3 percentage points.

The yellow boxes (C) indicate that performance demonstrates opportunities for improvement. One of the two P4P goals was met.

- Either the MCO's MY 2022 performance indicator(s) are below/worse than the MY 2022 performance benchmark, but improved in MY 2022 compared to MY 2021 by greater than or equal to 0.5 percentage points but less than 3 percentage points; or
- the MCO's MY 2022 performance indicator(s) MY 2022 are above/better than the MY 2022 performance benchmark, but
    - improved in MY 2022 compared to MY 2021 by less than 0.5 percentage points or
    - declined in MY 2022 compared to MY 2021 by no greater than 3 percentage points.

The orange boxes (D) indicate that performance does not meet the standards or is trending in the wrong direction.

- Either the MCOs MY 2022 performance indicator(s) are below/worse than the MY 2022 performance benchmark and
    - improved in MY 2022 compared to MY 2021 by less than 0.5 percentage points or
    - declined in MY 2022 compared to MY 2021 by no greater than 3 percentage points; or
- the MCO's MY 2022 performance indicator(s) are above/better than the MY 2022 performance benchmark, but the MY 2022 performance indicator(s) declined by greater than 3 percentage points compared to MY 2021.

The red box (F) indicates that performance does not meet the standards and declined considerably. Neither P4P goals were met. The MCOs MY 2022 performance indicator(s) are below/worse than the MY 2022 performance benchmark and are below/worse in MY 2022 compared to MY 2021 by greater than 3 percentage points.

PHW Key Points

▪ A – Benchmark is met. MCO achieved optimal improvement.

Performance indicators(s) that are above/better than the MY 2022 performance benchmark, and in MY 2022 are above/better than MY 2021 by greater than or equal to 3 percentage points:

- Comprehensive Assessment and Update
- Comprehensive Care Plan Update
- Reassessment and Care Plan Update After Inpatient Discharge
- Shared Care Plan with Primary Care Practitioner
- Number of participants who successfully transitioned from the NF to the community

▪ B – Benchmark is met and/or MCO achieved notable improvement.

Performance indicators(s) that are above/better than the MY 2022 performance benchmark, and in MY 2022 are above/better than MY 2021 by greater than or equal to 0.5 percentage points but less than 3 percentage points:

- No MY 2022 performance indicators fell in this category

Performance indicator(s) that in MY 2022 are below/worse than the MY 2022 performance benchmark, but improved in MY 2022 compared to MY 2021 by greater than 3 percentage points:

- No MY 2022 performance indicators fell in this category

- **C – MCO met one of two P4P goals.**

Performance indicator(s) that in MY 2022 are below/worse than the MY 2022 performance benchmark, but improved in MY 2022 compared to MY 2021 by more than or equal to 0.5 percentage points but less than 3 percentage points:

- Overall Satisfaction with Health Plan

Performance indicator(s) that in MY 2022 are above/better than the MY 2022 performance benchmark, but improved in MY 2022 compared to MY 2021 by less than 0.5 percentage points or declined in MY 2022 by no greater than 3 percentage points:

- No MY 2022 performance indicators fell in this category

- **D – MCO performance does not meet the standards or is trending in the wrong direction**

Performance indicator(s) that in MY 2022 are below/worse than the MY 2022 performance benchmark, and improved in MY 2022 compared to MY 2021 by less than 0.5 percentage points or declined in MY 2022 by no more than 3 percentage points:

- No MY 2022 performance indicators fell in this category

Performance indicator(s) that in MY 2022 are above/better than the MY 2022 performance benchmark and declined in MY 2022 compared to MY 2021 by greater than 3 percentage points:

- No MY 2022 performance indicators fell in this category

- **F – MCO did not meet either P4P goal. MCO performance declined considerably.**

Performance indicator(s) that in MY 2022 are below/worse than the MY 2022 performance benchmark, and are below/worse in MY 2022 compared to MY 2021 by greater than 3 percentage points:

- PCSP Included All Things Important to You

	Medicaid Managed Care Benchmark Comparison		
Year to Year Comparison	**Trend**	**Below the Benchmark**	**Above the Benchmark**
	Improvement equaled or exceeded 3 percentage points	**B**	**A** Comprehensive Assessment and Update Comprehensive Care Plan Update Reassessment and Care Plan Update After Inpatient Discharge Shared Care Plan with Primary Care Practitioner Number of participants who successfully transitioned from the NF to the community
	Improvement was greater than or equal to 0.5 percentage points but less than 3 percentage points.	**C** Overall Satisfaction with Health Plan	**B**
	Improvement was less than 0.5 percentage points or decline was no more than 3 percentage points	**D** Orange	**C**
	Decline was greater than 3 percentage points.	**F** PCSP Included All Things Important to You	**D**

Figure 1: P4P Performance Indicator Matrix

Table 28 displays PHW's MY 2022 P4P results. Incentive payments were split between the two program goals: 50% of the funds allocated to the benchmark performance and 50% to incremental improvement. Performance indicator improvements for MY 2022 compared to MY 2021 earned the MCO an incentive payment based on the following sliding scale:

- ≥ 3 percentage point improvement: 100% of the measure value
- ≥ 2 and < 3 percentage point improvement: 85% of the measure value.
- ≥ 1 and < 2 percentage point improvement: 75% of the measure value.
- ≥ 0.5 and < 1 percentage point improvement: 50 percent of the measure value
- < 0.5 percentage point improvement: no payout.

Table 28: PHW MY 2022 P4P Results

Indicator Description	MY 2022 Benchmark Goal	MY 2022 Performance Results	Benchmark Goal Met (Yes or No)	MY 2021 Performance Results	MY 2022 Performance Results	Goal Met (Yes or No)	Percentage Point Change
	PHW Benchmark Standard			PHW Improvement Standard			
Comprehensive Assessment and Update (CAU)	78.0%	86.5%	Yes	52.1	86.5%	Yes	34.4
Comprehensive Care Plan Update (CPU)	78.0%	80.2%	Yes	55.2	80.2%	Yes	25.0
Reassessment and Care Plan Update After Inpatient Discharge (RAC)	38.0%	57.3%	Yes	36.5	57.3%	Yes	20.8
Share Care Plan with Primary Care Practitioner (SCP)	55.0%	69.8%	Yes	45.8	69.8%	Yes	24.0
Overall Satisfaction with Health Plan (aligned SNP/Medicaid only population)	83.0%	78.8%	No	78.0	78.8%	Yes	0.8
Person-Centered Services Plan Included All Things Important to You	70.0%	63.0%	No	68.0	63.0%	No	-5.0
Number of participants successfully transitioned from the NF to the community and remained there for at least six months.	380	389	Yes	273	389	Yes	42.5

SNP: special needs plan; NF: nursing facility; CAHPS:

Appendix

A1 Performance Improvement Project Interventions

As referenced in **Section I: Performance Improvement Projects**, **Appendix Table A1** lists all of the interventions outlined in the MCO's most recent PIP submission for the review year.

Appendix Table A1

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.
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.

Summary of Interventions
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.