Commonwealth of Pennsylvania
Department of Human Services
Office of Long-Term Living

External Quality Review

Community HealthChoices Managed Care Organization Technical Report for UPMC Health Plan, January – December 2021

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Introduction

Purpose and Background

The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a MCO furnishes to Managed Care recipients. The Centers for Medicare & Medicaid Services (CMS) is required to develop EQR protocols to guide and support the annual EQR process. The first set of protocols was issued in 2003 and updated in 2012. CMS revised the protocols in 2018 to incorporate regulatory changes contained in the May 2016 Medicaid and CHIP managed care final rule, including the incorporation of CHC MCOs. Updated protocols were published in late 2019.

The Pennsylvania (PA) Department of Human Services (DHS) Community HealthChoices (CHC) is the mandatory managed care program in PA for adults dually-eligible for Medicare and Medicaid, and for older adults, and adults with physical disabilities, in need of long-term services and supports. Long-term services and supports (LTSS) help individuals perform daily activities in their home such as bathing, dressing, preparing meals, and administering medications. 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-driven LTSS system, in which people have a full array of quality services and supports that foster independence, health, and quality of life.

CHC was phased in over a three-year period: Phase 1 began January 1, 2018 in the Southwest region (Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties); Phase 2 began January 1, 2019, in the Southeast region (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties); and Phase 3 began January 1, 2020, in the remaining part of the state (Lehigh/Capital, Northwest, and Northeast). Statewide, PA DHS Office of Long-Term Living (OLTL) contracts with MCOs to provide CHC benefits to members.

The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by the contracted Medicaid Managed Care Organization (MCO). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that the MCO furnishes to Medicaid Managed Care recipients. This is conducted in conjunction with the PA DHS's Quality Strategy, which IPRO also evaluates as part of the statewide Annual Technical Report.

The mandatory EQR-related activities that must be included in detailed technical reports, per 42 CFR §438.358, are as follows:

- validation of performance improvement projects,
- validation of MCO performance measures, and
- review of compliance with Medicaid and CHIP managed care regulations.

It should be noted that a fourth mandatory activity, validation of network adequacy, was named in the CMS *External Quality Review (EQR) Protocols* published in October 2019. However, CMS has not published an official protocol for this activity, and this activity is conducted at the state's discretion. Each managed care program agreement entered into by the Department identifies network adequacy standards for those programs.

The PA DHS OLTL (hereafter "the Department") contracted with its EQRO, IPRO (hereafter "the EQRO"), to conduct the 2021 EQRs for the CHC MCOs and to prepare the technical reports. This EQR MCO Technical Report presents, in terms of CHC, a review of UPMC Health Plan (UPMC; hereafter, UPMC is synonymous with "the MCO").

This technical report includes six core sections:

I. Performance Improvement Projects
II. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys
III. Structure and Operations Standards
IV. 2020 Opportunities for Improvement – MCO Response
V. 2021 Strengths and Opportunities for Improvement
VI. Summary of Activities

Information for **Section I** of this report is derived from activities conducted with and on behalf of the Department to research, select, and define Performance Improvement Projects (PIPs) for a new validation cycle, as well as the EQRO's validation of each MCO's PIPs, including review of the PIP design and implementation using documents provided by the MCO.

Information for **Section II** of this report is derived from the EQRO's validation of each MCO's performance measure submissions. Performance measure validation as conducted by the EQRO includes applicable PA-specific performance measures as well as Healthcare Effectiveness Data and Information Set (HEDIS®) measures for each MCO. Within **Section II**, CAHPS Survey validation results follow the performance measures.

Historically for the MCOs, the information for the compliance with Structure and Operations Standards in **Section III** of the report was derived from the results of on-site reviews conducted by the Department's internal staff, with findings entered into the Department's on-site monitoring tool, and follow up materials provided as needed or requested. Beginning in 2021, compliance data were collected from the Department's monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from OLTL's contract agreements with the MCOs, and from National Committee for Quality Assurance (NCQA™) accreditation results for each MCO. Standards presented in the on-site tool are those currently reviewed and utilized by PA OLTL staff to conduct reviews; these standards may be applicable to other subparts and will be cross walked to reflect regulations as applicable.

Section IV, 2020 Opportunities for Improvement – MCO Response, includes the MCO's responses to the 2020 EQR Technical Report's opportunities for improvement and presents the degree to which the MCO addressed each opportunity for improvement.

Section V has a summary of the MCO's strengths and opportunities for improvement for this review period as determined by the EQRO. This section will highlight performance measures across HEDIS and Pennsylvania-specific performance measures where the MCO has performed highest and lowest.

Section VI contains a summary of findings across all sections of the EQR Technical Reports, including Structure and Operations Standards, Performance Improvement Projects, Performance Measures, 2020 Opportunities for Improvement MCO Reponses, and Strengths and Opportunities for Improvement found for 2021.

I: Performance Improvement Projects

Objectives

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

In accordance with current BBA regulations, the EQRO undertook validation of PIPs for each MCO. For the purposes of the EQR, the MCO is required to participate in studies selected by the Department for review and validation of methodology in 2021 (CHC Agreement, 2021). Two PIPs (first initiated in 2018) were expanded and improved as part of this requirement. Over the course of implementation of all PIPs, the MCO must implement improvement actions and conduct follow-up to demonstrate initial and sustained improvement or the need for further action.

Since initiation of CHC PIPs, the EQRO has utilized 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. MCOs were provided with the most current Lean PIP submission and validation templates at the initiation of the PIPs.

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 NF to the Community.

"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 in the SW Region. Accordingly, the MCO submitted proposals for PIP expansion into the SE Region in September 2019 throughout the entirety of PA in September 2020. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly.

For this PIP, MCOs were required to submit rates at the baseline, interim, and final measurement years for transitions of care measures aligned with clinical care coordination, with indicators for notification of inpatient admission, receipt of discharge note, engagement after inpatient discharge, as well as a hospitalization follow-up indicator for seven-day follow up behavioral discharge. Additionally, indicators aligned with capabilities of information systems were developed and implemented to encompass transitional care planning and adjustments to improved notification of discharge.

"Transition of Care from the NF to the Community" was selected following discussions with stakeholders and in collaboration with the EQRO. The MCO was required to implement interventions and measure performance on the topic of transition of care from the nursing facility to the community, entailing assessment and improvement of outcomes of care rendered by the MCO. 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 throughout the entirety of PA in September 2020. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly.

For this PIP, MCOs were required to submit rates at the baseline, interim, and final measurement years for transitions of care measures, with indicators for receipt of discharge note, engagement after inpatient discharge, and medication reconciliation, and an indicator for remaining in home or community post-discharge. Additionally, an indicator aligned with capabilities of information systems was developed and implemented to encompass transitional care planning.

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

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

Technical Methods of Data Collection and Analysis

The EQRO's validation process begins at the PIP proposal phase and continues through the life of the PIP. During the conduct of the PIPs, the EQRO provides technical assistance to each MCO/MCP. The 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 EQRO's assessment involves the following. Each submitted PIP report is reviewed against applicable review elements and associated requirements. The first set of elements relates to the baseline and demonstrable improvement phases of the PIP. The last element relates to sustaining improvement from the baseline measurement.

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

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).

For PIP aim, the following are reviewed: aim specifies performance indicators 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.

For PIP methodology, the following are reviewed: performance indicators are clearly defined and measurable (specifying numerator and denominator criteria); performance indicators are measured consistently over time; performance indicators 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.

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.

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).

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

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.

For PIP sustainability, the following are reviewed: there are ongoing, additional, or modified interventions documented; and, sustained improvement was 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.

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. Measurement Year (MY 2018) is the initial baseline year, and during the 2021 review year, elements were reviewed at multiple points during the year and scored using the Year 2 annual reports submitted in 2021. All MCOs received some level of guidance towards improving their submissions in these findings, and MCOs will respond accordingly with resubmission to correct specific areas.

For each review element, the assessment of compliance is determined through the responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. The overall score is expressed in terms of levels of compliance. The elements are not formally scored beyond the full/partial/non-compliant determination.

Table 1.1 presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 1.1: Element Designation

Element Designation	Definition	Designation Weight
Full	Met or exceeded the element requirements	100%
Partial	Met essential requirements, but is deficient in some areas	50%
Non-compliant	Has not met the essential requirements of the element	0%

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. Untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into the overall determination. At the time each element is reviewed, a finding is given of “Met”, “Partially Met”, or “Not Met”. Elements receiving a “Met” will receive 100% of the points assigned to the element, “Partially Met” elements will receive 50% of the assigned points, and “Not Met” elements will receive 0%.

The total points earned for each review element are weighted to determine the MCO’s overall performance scores for a PIP. For the EQR PIPs, the review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance; refer to **Table 1.2**).

Table 1.2: 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[1]	20%
Total sustained improvement score		**20%**
Overall project performance score		**100%**

[1]At the time of this report, these standards were not yet applicable in the current phase of PIP implementation.

As also noted in **Table 1.2** (Scoring Matrix), PIPs are also reviewed for the achievement of sustained improvement. For the EQR of the MCO's PIPs, sustained improvement elements have a total weight of 20%, for a possible maximum total of 20 points. The MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements. The standards for demonstrable and sustainable improvement will be reported by the MCO and evaluated by the EQRO at the end of the current PIP cycle and reported in a subsequent BBA report.

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements for which activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. The same project will then be evaluated for other elements at a later date, according to the PIP submission schedule. Each element is scored. Elements that are met receive an evaluation score of 100%, elements that are partially met receive a score of 50%, and elements that are not met receive a score of 0%. Overall, for PIP implementation, compliance determinations are as follows: compliance is deemed met for scores ≥ 85%, partially met for scores 60–84%, and not met for scores < 60%. Corrective action plans are not warranted for CHC-MCOs that are compliant with PIP implementation requirements.

Findings

To encourage MCOs to focus on improving the quality of the projects, PIP reviews were assessed for compliance on all applicable elements and commented on accordingly. The multiple levels of activity and collaboration between the Department, the MCOs, and the EQRO continued and progressed throughout the review year.

Subsequent to MCO proposal submissions that were provided earlier, several levels of feedback were provided to MCOs. This feedback included:

- MCO-specific review findings for each PIP.
- Conference calls with each MCO as needed to discuss the PIP proposal review findings with key MCO staff assigned to each PIP topic.
- Information to assist MCOs in preparing their next full PIP submission, such as additional instructions regarding collection of the required performance indicators as well as considerations for additional expanding methodologies.

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

Implementation, which were subjected to EQR and scored for reporting the year's PIP compliance determinations, were submitted to the EQRO in March 2021 with updates on interventions through the first half of 2021 submitted to the EQRO in July 2021.

The following summarizes PIP compliance assessments for the MCO's Annual PIP Reports (Year 2 Implementation) review findings aligned with the determinations presented in **Table 1.3**. Upon request, the MCO's PIP reports and the EQRO's review findings can be made available for reference. **Table A.1** of the MCO's interventions for the PIPs can be found in the **Appendix** of this report.

Strengthening Care Coordination

For the Year 2 implementation review, the MCO scored 100% (80.0 points out of a maximum possible weighted score of 80.0 points). The MCO expanded PIP implementation statewide, into the Northeast, Northwest, and Lehigh Capital Regions, in accordance with the approved CHC Phase 3 Expansion Proposal submitted September 2020, which was reviewed by the EQRO and factored input from the Department. For two themes of the Performance Indicators (patient engagement after inpatient discharge, and medication reconciliation post-discharge) implemented broadly across regional and statewide aspects of the PIP, the bold goal rates used by the MCO could be further discussed (as noted by the MCO last year, "The goals were adjusted based upon the MCO's current data and feedback received from the EQRO stating that the goals should be between 50-75%") and rationalized in terms of being supported by evidence and logic (including if found to be unreasonable, based on incorporation of continuous improvement process information during the PIP's implementation). The MCO correctly indicated the baselines, which were clearly specified respective to the CHC Phases. Regarding earlier robustness of the interventions reported last year, improvements were noted for this Year 2 annual submission (and these improvements were aligned with the interim updates provided by the MCO prior to this submission). The MCO utilized comparable methodology across regions, which to an extent factors continuous improvement over the course of expanding implementation; to enhance the discussion, the MCO could also provide further detail about how the approved measurement methodology/specifications may warrant cautious interpretation when measures (and therefore results) are scaled to the statewide level (in which CHC is fully phased in for every region), in consideration to prior proposals focusing on a phase-specific regions, with different baselines for each phase. 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 2 implementation review, the MCO scored 96.9% (77.5 points out of a maximum possible weighted score of 80.0 points). The MCO expanded PIP implementation statewide, into the Northeast, Northwest, and Lehigh Capital Regions, in accordance with the approved CHC Phase 3 Expansion Proposal submitted September 2020, which was reviewed by the EQRO and factored input from the Department. The MCO correctly indicated the baselines, which were clearly specified respective to the CHC Phases. To continue enhancing clarity in reporting of data collection and analysis procedures, the MCO could better explain eligibility in terms of the sampling methods (Eligible population is initially defined for CHC Statewide, regarding the overall PIP and a subsequent identical statement is noted for sampling methodology for CHC Statewide; the MCO could clarify this statement as previous statements suggest that the entire CHC population is eligible for the interventions). The MCO generally improved intervention activity/robustness since last year's annual report submission; to further enhance this aspect, the MCO could enhance intervention descriptions in terms of the related barriers, regarding the following two considerations. Firstly, timely notification of pending discharges by the nursing facilities was identified as a barrier and the intervention is a timely notification policy, and the MCO could strengthen how this translates into an activity that is tracked to show progress in addressing the precise barrier at hand. Secondly, for Barrier #2a-c and corresponding Intervention #2a, the association could be strengthened by describing more precisely what occurs during the visit that is specific to addressing the barrier, since the Service Coordinator merely having a visit with the participant is already the expectation. As part of making enhancements to interventions, the MCO could consider how it could better apply barrier analysis findings to calibrate a given intervention and/or make decisions relating to the methodology and ensure ITMs correspond accordingly. For two PIs for Phase 3 measurement (PI #2 and #3), the MCO could relate potential challenges if it anticipates being unable to meet the associated goals for these PIs for Phase 3, in consideration to the very brief window (one business day) utilized for these measurements (e.g., regarding staffing difficulties and/or a myriad of other communication difficulties). In general, the MCO 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 1.3: UPMC PIP Compliance Assessments – Final Reports

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	Partially Met
Element 7. Discussion and Validity of Reported Improvement	Met	Met

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

For both PIPs, compliance was deemed met as both PIPs' scores exceeded ≥ 85%. **No recommendation was included for the MCO to improve its score to exceed the threshold for compliance.**

II: Performance Measures and CAHPS Surveys

Methodology

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

Starting in December 2020, technical specifications for performance measures, 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 2021 measures from the NCQA publication, *HEDIS 2021 Volume 2: Technical Specifications*, were validated through a standard HEDIS compliance audit of each MCO. 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 performance measures 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 2021 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 purposes.

Evaluation of MCO performance is based on both PA-specific performance measures and selected HEDIS measures for the EQR. A list of the performance measures included in this year's EQR report is presented in **Table 2.1**.

Table 2.1: Performance Measure Groupings

Source	Measures
Effectiveness of Care	
HEDIS	Adult BMI Assessment (ABA)
HEDIS	Breast Cancer Screening (BCS)
HEDIS	Cervical Cancer Screening (CCS)
HEDIS	Chlamydia Screening in Women (CHL)
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
HEDIS	Pharmacotherapy Management of COPD Exacerbation (PCE)
HEDIS	Medication Management for People With Asthma (MMA)
HEDIS	Asthma Medication Ratio (AMR)
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)
HEDIS	Comprehensive Diabetes Care (CDC)
HEDIS	Statin Therapy for Patients With Diabetes (SPD)
HEDIS	Antidepressant Medication Management (AMM)
PA EQR	Antidepressant Medication Management (AMM)
HEDIS	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
HEDIS	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
HEDIS	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)
HEDIS	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)
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)
HEDIS	Risk of Continued Opioid Use (COU)
HEDIS	Pharmacotherapy for Opioid Use Disorder (POD)

Source	Measures
HEDIS	Care for Older Adults (COA)
HEDIS	Transitions of Care (TRC)
Access/Availability of Care	
PA EQR	Adult Annual Dental Visit (AADV)
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (AAP)
HEDIS	Comprehensive Assessment and Update (CAU)
HEDIS	Comprehensive Care Plan and Update (CPU)
HEDIS	Shared Care Plan with Primary Care Practitioner (SCP)
HEDIS	Reassessment/Care Plan Update After Inpatient Discharge (RAC)
PA EQR	Comprehensive Assessment and Update (CAU)
PA EQR	Comprehensive Care Plan and Update (CPU)
PA EQR	Shared Care Plan with Primary Care Practitioner (SCP)
PA EQR	Reassessment/Care Plan Update After Inpatient Discharge (RAC)
Utilization and Risk-Adjusted Utilization	
HEDIS	Frequency of Selected Procedures (FSP)
HEDIS	Ambulatory Care (AMB)
HEDIS	Inpatient Utilization—General Hospital/Acute Care (IPU)
HEDIS	Antibiotic Utilization (ABX)
HEDIS	Plan All-Cause Readmissions (PCR)

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

Several PA-specific performance measures were calculated by each MCO and validated by the EQRO. In accordance with direction from the Department, the EQRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria that were generally specified to identify the eligible population product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications, as needed. PA-specific performance measure rates were calculated administratively, which uses only the MCOs data systems to identify numerator positives; additionally, a hybrid methodology, which uses a combination of administrative data and medical record review validation (MRRV) to identify corresponding numerator "hits" for rate calculations, was used in LTSS PMs.

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, with several exceptions: measures excluded from the complete Medicaid HEDIS data set are measures which are childhood-related and pregnancy-related, as well as those involving behavioral health (behavior health being carved out in PA). MCOs were required to report in accordance with HEDIS MY 2020 product line technical specifications and to follow the NCQA timeline (notably, on or before June 15, 2021: 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 2020 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.

Due to the NCQA requirement of alignment of HEDIS and CAHPS reporting populations, a set of IDSSs were produced and submitted. The entire 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 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., DSNP enrollment is not aligned with the MCO, or the member has another Medicare Advantage or FFS plan). All three groups were required to report the LTSS measures.

Since Mental Health (MH)/Chemical Dependency (CD) is carved out in PA, members dually enrolled in Medicare and Medicaid had MH/CD benefits through Medicare only. Benefits were assessed for dually-enrolled members for each product in which they were reported. Therefore, when reporting for the Medicaid population, MH/CD measures were not reported since the benefit is carved out for Medicaid. Data was also not collected on members who were continuously enrolled in another product within the MCO prior to the initiation of the CHC program. Additionally, no Electronic Clinical Data Systems (ECDS) measures were required.

HEDIS and CAHPS reporting populations were aligned in accordance with the NCQA requirement. Therefore, the CAHPS reporting populations were aligned to same three benefit structures. The set of three CAHPS sample frames were validated. The set entailed two (2) sampling frames: a Medicaid Adult CAHPS sampling frame (aligned with the Medicaid IDSS) and one Medicaid Adult CAHPS sampling frame for just the third group. Per agreement with the Department: MCOs submitted CAHPS files for Adult Medicaid according to NCQA guidelines specified in the NCQA publication, *HEDIS MY 2020 Volume 3: Specifications for Survey Measures*; in addition, the Adult CAHPS was completed with the inclusions of PA-specific supplemental dental questions. Of additional note: Care for Older Adults (COA), one of the two Medicare measures, is required for Special Needs Plans and Medicare-Medicaid Plans only; and, measures with continuous enrollment criteria greater than one (1) year would not capture membership in the latest expansion regions for CHC Phase 3 (i.e., NE, NW, Lehigh and Capital Regions).

CAHPS Survey

The Consumer Assessment of Healthcare Providers and Systems (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.

Implementation of PA-Specific Performance Measures and HEDIS Audit

In early 2021, an initial opportunity for improvement was identified for one MY 2019 PA-specific performance measure (PAPM validation additionally included MY 2019 due to COVID-19 delays) pertaining to Access to/Availability of Care: for the 2020 reporting requirement for the LTSS Shared Care Plan (SCP) measure, UPMC was found to have an issue with its ability to produce a valid result as CHC was rolled out into the Southeast Region for Phase 2. The purpose of this SCP measure was to report compliance with member care plans' transmission to the PCP (or to another documented practitioner) within 30 days of the date when the member agreed to the care plan, i.e., 31 days total (evidence of care plan transmission includes: to whom the care plan was transmitted; the date of transmission; and, a copy of the transmitted plan or plan sections). There was insufficient evidence that care plans were transmitted to or shared with PCPs during the measurement period. Consequently, for MY 2019, the result was deemed biased and invalid.

The MCO implemented all of the PA-specific measures for MY 2020, which were reported with MCO-submitted data. The MCO submitted all required source code and data for review (which the EQRO reviewed the source code and validated raw data submitted by the MCO). Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures. The aforementioned issue pertaining specifically to the SCP results for MY 2019 was found to recur for the SCP results for MY 2020.

The MCO successfully completed the 2021 (MY 2020) NCQA Compliance Audit for certified HEDIS performance measures and CAHPS. The MCO received an Audit Designation of Reportable for all applicable NCQA-certified measures.

Conclusions and Comparative Findings

In 2021, an initial validation issue that impacted the MY 2019 SCP results was identified during the process in terms of timeliness and accuracy of requested information from the MCO, which were required to complete validation. Based on discussions with the Department, the CHC MCO was required to improve compliance per the CHC Agreement (EQRO Requirements, Section V.CC.5 "External Quality Review"). In response, the MCO advised improvements are in process and anticipates the issue to be resolved in 2022.

Table 2.2 through **Table 2.4**, below, summarize the MCO's MY 2020 HEDIS and PA EQR performance measure results, with noteworthy findings listed underneath the table.

In addition to each individual MCO rate, the CHC Medicaid Managed Care (MMC) average for 2021 (MY 2020) is presented. The CHC MMC average is a weighted average, which is an average that takes into account the proportional relevance of each MCO. Rates for the CHC HEDIS measures were not compared to corresponding Medicaid percentiles. At the time of this report, benchmarks for comparison were not available or not applicable.

Effectiveness of Care

Table 2.2 presents the MCO's 2021 (MY 2020) performance measure rates for Effectiveness of Care.

Table 2.2: 2021 (MY 2020) Performance Measure Rates for Effectiveness of Care

Performance Measure	UPMC	PADHS Mean	Weighted Average
Effectiveness of Care			
Prevention and Screening			
Breast Cancer Screening (BCS) – Administrative			
BCS: Rate	65.37%	52.50%	63.94%
Cervical Cancer Screening (CCS) – Hybrid			
CCS: Rate	52.67%	40.72%	46.98%
Chlamydia Screening in Women (CHL) – Administrative			
CHL: Ages 21 - 24 years	25.00%	25.00%	25.00%
CHL: Total Rate	25.00%	25.00%	25.00%
Care for Older Adults (COA) – Hybrid			
COA: Advance Care Planning	57.42%	50.31%	52.82%
COA: Medication Review	83.45%	84.77%	84.76%
COA: Functional Status Assessment	67.88%	66.78%	67.56%
COA: Pain Assessment	82.00%	84.30%	83.83%
Respiratory Conditions			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Administrative			
AAB: Ages 18 - 64 years	38.13%	39.29%	39.08%
AAB: Ages 65+ years	31.13%	40.57%	37.34%
AAB: Total Rate	36.30%	40.04%	38.87%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) – Administrative			
SPR: Rate	23.91%	23.54%	24.16%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Administrative			
PCE: Systemic Corticosteroid	77.45%	74.54%	76.50%
PCE: Bronchodilator	87.04%	88.75%	89.08%
Asthma Medication Ratio (AMR) – Administrative			
AMR: Ages 19 - 50 years	60.79%	59.75%	59.70%
AMR: Ages 51 - 64 years	64.20%	53.45%	53.50%
AMR: Total Rate	62.55%	55.36%	55.87%
Cardiovascular Conditions			
Controlling High Blood Pressure (CBP) – Hybrid			
CBP: Total Rate	70.32%	56.63%	57.77%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) – Administrative			
PBH: Rate	95.29%	92.17%	92.40%
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Administrative			
SPC: Received Statin Therapy - Ages 21-75 years (Male)	86.17%	85.58%	86.39%
SPC: Received Statin Therapy - Ages 40-75 years (Female)	80.61%	84.68%	82.99%
SPC: Received Statin Therapy - Total Rate	83.17%	85.57%	84.57%
SPC: Statin Adherence 80% - Ages 21-75 years (Male)	88.37%	80.96%	85.84%
SPC: Statin Adherence 80% - Ages 40-75 years (Female)	88.03%	82.15%	85.65%
SPC: Statin Adherence 80% - Total Rate	88.19%	81.55%	85.73%

Performance Measure	UPMC	PADHS Mean	Weighted Average
Effectiveness of Care			
Cardiac Rehabilitation (CRE) – Administrative			
CRE: Initiation - 2 or more sessions within 30 days (Ages 18-64)	1.45%	1.18%	1.17%
CRE: Initiation - 2 or more sessions within 30 days (Ages 65+)	0.00%	0.00%	0.00%
CRE: Initiation - 2 or more sessions within 30 days (Total)	1.14%	1.20%	1.23%
CRE: Engagement 1 - 12 or more sessions within 90 days (Ages 18-64)	3.78%	2.75%	2.48%
CRE: Engagement 1 - 12 or more sessions within 90 days (Ages 65+)	3.19%	3.19%	3.19%
CRE: Engagement 1 - 12 or more sessions within 90 days (Total)	3.65%	2.94%	2.57%
CRE: Engagement 2 - 24 or more sessions within 180 days (Ages 18-64)	2.62%	2.16%	2.09%
CRE: Engagement 2 - 24 or more sessions within 180 days (Ages 65+)	4.26%	4.26%	4.26%
CRE: Engagement 2 - 24 or more sessions within 180 days (Total)	2.97%	2.53%	2.35%
CRE: Achievement - 36 or more sessions within 180 days (Ages 18-64)	0.87%	1.18%	0.78%
CRE: Achievement - 36 or more sessions within 180 days (Ages 18-64)	3.19%	3.19%	3.19%
CRE: Achievement - 36 or more sessions within 180 days (Total)	1.37%	1.63%	1.11%
Diabetes			
Comprehensive Diabetes Care (CDC) – Hybrid			
CDC: HbA1c Testing	86.37%	83.93%	84.09%
CDC: HbA1c Poor Control (>9.0%)	35.77%	46.32%	43.73%
CDC: HbA1c Control (<8.0%)	56.93%	46.07%	49.21%
CDC: Eye Exam	68.61%	50.46%	57.01%
CDC: Blood Pressure Controlled (<140/90 mm Hg)	64.72%	51.30%	50.94%
Statin Therapy for Patients With Diabetes (SPD) – Administrative			
SPD: Received Statin Therapy	74.78%	76.33%	75.45%
SPD: Statin Adherence 80%	84.82%	79.78%	81.50%
Kidney Health Evaluation for Patients with Diabetes (KED) – Administrative			
KED: Ages 18 - 64 years	40.43%	34.77%	36.52%
KED: Ages 65 - 74 years	44.13%	42.40%	43.32%
KED: Ages 75 - 85 years	40.41%	39.81%	41.71%
KED: Total Rate	41.43%	36.24%	38.34%
Musculoskeletal			
Use of Imaging Studies for Low Back Pain (LBP) – Administrative			
LBP: Rate	75.64%	76.21%	77.18%
Behavioral Health			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) – Administrative			
SSD: Rate	82.36%	82.00%	81.40%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) – Administrative			
SMD: Rate	75.83%	65.47%	68.86%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) – Administrative			
SMC: Rate	77.27%	76.14%	76.61%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) – Administrative			
SAA: Rate	84.00%	76.63%	78.96%
Pharmacotherapy for Opioid Use Disorder (POD) – Administrative			
POD: Ages 16 - 64 years	50.72%	40.67%	42.78%
POD: Ages 65+ years	44.44%	44.44%	44.44%
POD: Total Rate	49.80%	39.38%	42.37%
Antidepressant Medication Management (AMM)			
AMM: Effective Acute Phase Treatment	71.69%	67.95%	69.00%
AMM (PA EQR): Effective Acute Phase Treatment	77.71%	54.74%	36.60%

Performance Measure	UPMC	PADHS Mean	Weighted Average
Effectiveness of Care			
AMM: Effective Continuation Phase Treatment	59.13%	58.42%	57.55%
Medication Management and Care Coordination			
Transitions of Care (TRC) – Hybrid			
TRC: Notification of Inpatient Admission (Ages 18-64)	35.71%	13.48%	27.49%
TRC: Notification of Inpatient Admission (Ages 65+)	40.11%	16.61%	28.75%
TRC: Notification of Inpatient Admission (Total)	37.94%	14.94%	28.15%
TRC: Medication Reconciliation Post-Discharge (Ages 18-64)	51.10%	52.17%	51.93%
TRC: Medication Reconciliation Post-Discharge (Ages 65+)	66.84%	62.82%	66.38%
TRC: Medication Reconciliation Post-Discharge (Total)	59.08%	57.58%	59.66%
TRC: Patient Engagement After Inpatient Discharge (Ages 18-64)	84.07%	75.51%	81.19%
TRC: Patient Engagement After Inpatient Discharge (Ages 65+)	87.70%	82.89%	85.69%
TRC: Patient Engagement After Inpatient Discharge (Total)	85.91%	79.41%	83.64%
TRC: Receipt of Discharge Information (Ages 18-64)	31.87%	12.39%	24.39%
TRC: Receipt of Discharge Information (Ages 65+)	33.69%	14.51%	23.96%
TRC: Receipt of Discharge Information (Total)	32.79%	13.38%	24.15%
Overuse/Appropriateness			
Risk of Continued Opioid Use (COU) – Administrative			
COU: Ages 18-64 years - >=15 Days covered	14.28%	16.24%	17.55%
COU: Ages 65+ years - >=15 Days covered	20.86%	18.00%	19.61%
COU: Total - >=15 Days covered	16.47%	16.78%	18.08%
COU: Ages 18-64 years - >=31 Days covered	9.33%	12.47%	12.89%
COU: Ages 65+ years - >=31 Days covered	11.92%	11.20%	11.82%
COU: Total - >=31 Days covered	10.19%	12.37%	12.61%
Use of Opioids at High Dosage (HDO) – Administrative			
HDO: Rate	9.55%	11.60%	11.05%
Use of Opioids From Multiple Providers (UOP) – Administrative			
UOP: Rate receiving prescription opioids (4 or more prescribers)	16.31%	13.28%	14.58%
UOP: Rate receiving prescription opioids (4 or more pharmacies)	1.87%	1.41%	1.84%
UOP: Rate receiving prescription opioids (4 or more prescribers & pharmacies)	1.08%	0.53%	0.90%

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; CHC: Community HealthChoices; PADHS: Pennsylvania Department of Human Services; NA: not applicable due to small denominator.

No strengths were identified for the 2021 (MY 2020) Effectiveness of Care performance measures.

No opportunities for improvement are identified for the 2021 (MY 2020) Effectiveness of Care performance measures.

While all measures in the Effectiveness of Care domain were considered reportable for NCQA audit purposes, the rates could be reviewed and improvement strategies could be considered, where warranted; further comparisons in subsequent reports (including to applicable benchmarks) can be used for identification of strengths and/or opportunities for improvement.

Access/Availability of Care

Table 2.3 presents the MCO's 2021 (MY 2020) performance measure rates for Access/Availability of Care.

Table 2.3: 2021 (MY 2020) Performance Measure Rates for Access/Availability of Care

Performance Measure	UPMC	PADHS Mean	Weighted Average
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Administrative			
AAP: Ages 20 - 44 years	92.89%	91.21%	91.47%
AAP: Ages 45 - 64 years	96.97%	96.03%	96.16%
AAP: Ages 65+ years	96.55%	94.65%	95.65%
AAP: Total Rate	96.24%	94.87%	95.28%
Adult Annual Dental Visit (AADV) – Administrative			
AADV (PA EQR): Total Rate	22.05%	18.41%	17.58%
Long-Term Services and Supports			
Comprehensive Assessment and Update (CAU) – Hybrid			
CAU: Assessment of Core Elements	69.79%	70.57%	65.61%
CAU: Assessment of Supplemental Elements	69.79%	70.57%	65.61%
CAU (PA EQR): Assessment of Core Elements	73.96%	54.17%	54.17%
CAU (PA EQR): Assessment of Supplemental Elements	90.63%	59.72%	59.72%
Comprehensive Care Plan and Update (CPU) – Hybrid			
CPU: Care Plan with Core Elements Documented	41.67%	69.01%	65.33%
CPU: Assessment of Supplemental Elements	41.67%	67.19%	62.96%
CPU (PA EQR): Care Plan with Core Elements Documented	30.21%	40.63%	40.63%
CPU (PA EQR): Assessment of Supplemental Elements	70.83%	54.17%	54.17%
Shared Care Plan with Primary Care Practitioner (SCP) – Hybrid			
SCP: Shared Care Plan with Primary Care Practitioner	0.00%[1]	40.84%	34.73%
SCP (PA EQR): Shared Care Plan with Primary Care Practitioner	NR[1]	19.31%	18.75%
Reassessment/Care Plan Update After Inpatient Discharge (RAC) – Hybrid			
RAC: Reassessment After Inpatient Discharge	30.23%	33.86%	32.45%
RAC: Reassessment and Care Plan Update After Inpatient Discharge	13.95%	27.97%	23.91%
RAC (PA EQR): Reassessment After Inpatient Discharge	65.85%	44.87%	39.91%
RAC (PA EQR): Reassessment & Care Plan Update After Inpatient Discharge	31.71%	31.06%	30.90%

[1] The MCO calculated a rate of zero percent (0%) for LTSS SCP, which was deemed biased/invalid in MY 2020.

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; CHC: Community HealthChoices; PADHS: Pennsylvania Department of Human Services.

No strengths were identified for the 2021 (MY 2020) Access to/Availability of Care performance measures.

An opportunity for improvement was identified for the 2021 (MY 2020) Access to/Availability of Care performance measures.

- For one Access/Availability of Care performance measure, the MCO was found to have an issue in its capacity to produce a valid measurement for the LTSS Shared Care Plan (SCP) measure. UPMC was found to have an issue in early 2021 with its ability to produce the measure for PA EQR as CHC expanded for Phase 2, i.e., for MY 2019 as CHC expanded into the Southeast Region. The MCO reported a zero rate (0%) for MY 2019, which based on review of the eligibility, was deemed biased and invalid extending to MY 2020. Upon further review during 2021, challenges with this measure were elucidated as being due to care management systems issues. Data resources for numerator compliance were not available due to the inability to export the service plans to the provider portal, and a reportable rate was not calculated. The EQRO recommends that the MCO addresses these issues for subsequent reporting requirements for MY 2021.

All certifiable measures in the Access/Availability of Care domain were considered reportable for NCQA audit purposes. These rates could be reviewed, and improvement strategies could be considered, where warranted; further comparisons in subsequent reports (including to applicable benchmarks) can be used for identification of strengths and/or opportunities for improvement.

Utilization and Risk-Adjusted Utilization

Table 2.4 presents the MCO's 2021 (MY 2020) HEDIS performance measure results for Utilization and Risk-Adjusted Utilization. For Utilization and Risk-Adjusted Utilization measurement, the field for weighted average is shaded; weighted average is not applicable for this category of measurement.

Table 2.4: 2021 (MY 2020) Performance Measure Results for Utilization and Risk-Adjusted Utilization

Performance Measure	UPMC	PADHS Mean	Weighted Average
Utilization and Risk Adjusted Utilization			
Utilization			
Frequency of Selected Procedures (FSP) – Administrative			
FSP: Bariatric Weight Loss Surgery F Ages 20-44 Procs/1000 MM	0.54	0.38	
FSP: Bariatric Weight Loss Surgery F Ages 45-64 Procs/1000 MM	0.14	0.20	
FSP: Bariatric Weight Loss Surgery M Ages 20-44 Procs/1000 MM	0.04	0.06	
FSP: Bariatric Weight Loss Surgery M Ages 45-64 Procs/1000 MM	0.15	0.07	
FSP: Hysterectomy Abdominal F Ages 15-44 Procs/1000 MM	0.10	0.20	
FSP: Hysterectomy Abdominal F Ages 45-64 Procs/1000 MM	0.11	0.10	
FSP: Hysterectomy Vaginal F Ages 15-44 Procs/1000 MM	0.16	0.05	
FSP: Hysterectomy Vaginal F Ages 45-64 Procs/1000 MM	0.07	0.04	
FSP: Cholecystectomy, Open M Ages 30-64 Procs/1000 MM	0.08	0.04	
FSP: Cholecystectomy, Open F Ages 15-44 Procs/1000 MM	0.00	0.03	
FSP: Cholecystectomy Open F Ages 45-64 Procs/1000 MM	0.01	0.03	
FSP: Cholecystectomy Closed M Ages 30-64 Procs/1000 MM	0.45	0.33	
FSP: Cholecystectomy Closed F Ages 15-44 Procs/1000 MM	0.82	0.41	
FSP: Cholecystectomy Closed F Ages 45-64 Procs/1000 MM	0.55	0.44	
FSP: Back Surgery M Ages 20-44 Procs/1000 MM	0.33	0.28	
FSP: Back Surgery F Ages 20-44 Procs/1000 MM	0.73	0.36	
FSP: Back Surgery M Ages 45-64 Procs/1000 MM	0.64	0.49	
FSP: Back Surgery F Ages 45-64 Procs/1000 MM	0.98	0.81	
FSP: Mastectomy F Ages 15-44 Procs/1000 MM	0.10	0.18	
FSP: Mastectomy F Ages 45-64 Procs/1000 MM	0.13	0.10	
FSP: Lumpectomy F Ages 15-44 Procs/1000 MM	0.22	0.17	
FSP: Lumpectomy F Ages 45-64 Procs/1000 MM	0.25	0.22	
Ambulatory Care: Total (AMBA) – Administrative			
AMBA: Outpatient Visits/1000 MM	1,080.30	911.44	
AMBA: Emergency Department Visits/1000 MM	74.48	80.70	
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA) – Administrative			
IPUA: Total Discharges/1000 MM	26.32	33.17	
IPUA: Medicine Discharges/1000 MM	16.99	23.78	
IPUA: Surgery Discharges/1000 MM	9.19	9.21	
IPUA: Maternity Discharges/1000 MM	0.24	0.25	
Antibiotic Utilization: Total (ABXA) – Administrative			
ABXA: Total # of Antibiotic Prescriptions M&F	71,546	29,590	
ABXA: Average # of Antibiotic Prescriptions PMPY M&F	2.08	1.66	
ABXA: Total Days Supplied for All Antibiotic Prescriptions M&F	663,919	281,741	
ABXA: Average # Days Supplied per Antibiotic Prescription M&F	9.28	9.76	
ABXA: Total # of Prescriptions for Antibiotics of Concern M&F	33,052	13,387	

Performance Measure	UPMC	PADHS Mean	Weighted Average
Utilization and Risk Adjusted Utilization			
ABXA: Average # of Prescriptions for Antibiotics of Concern M&F	0.96	0.74	
ABXA: Percent Antibiotics of Concern of All Antibiotic Prescriptions	46.20	44.20	
Risk Adjusted Utilization			
Plan All-Cause Readmissions (PCR) – Administrative			
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 18-44)	257	229	
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 45-54)	441	365	
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages 55-64)	961	761	
PCR: Count of Index Hospital Stays (IHS) - Total Stays (Ages Total)	1,659	1,355	
PCR: Count of Observed 30-Day Readmissions - Total Stays (Ages 18-44)	32	36	
PCR: Count of Observed 30-Day Readmissions - Total Stays (Ages 45-54)	46	56	
PCR: Count of Observed 30-Day Readmissions - Total Stays (Ages 55-64)	137	119	
PCR: Count of Observed 30-Day Readmissions - Total Stays (Ages Total)	215	211	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages 18-44)	29.68	25.75	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages 45-54)	55.87	46.22	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages 55-64)	134.80	106.49	
PCR: Count of Expected 30-Day Readmissions - Total Stays (Ages Total)	220.36	178.46	
PCR: Observed Readmission Rate - Total Stays (Ages 18-44)	12.45%	14.89%	
PCR: Observed Readmission Rate - Total Stays (Ages 45-54)	10.43%	19.32%	
PCR: Observed Readmission Rate - Total Stays (Ages 55-64)	14.26%	18.58%	
PCR: Observed Readmission Rate - Total Stays (Ages Total)	12.96%	18.29%	
PCR: Expected Readmission Rate - Total Stays (Ages 18-44)	11.55%	11.90%	
PCR: Expected Readmission Rate - Total Stays (Ages 45-54)	12.67%	13.38%	
PCR: Expected Readmission Rate - Total Stays (Ages 55-64)	14.03%	14.62%	
PCR: Expected Readmission Rate - Total Stays (Ages Total)	13.28%	13.88%	
PCR: Observed to Expected Readmission Ratio - Total Stays (Ages Total)	0.98	1.30	

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; CHC: Community HealthChoices; PADHS: Pennsylvania Department of Human Services; BR: biased rate; the rate calculated by the MCO was biased.

No strengths were identified for the 2021 (MY 2020) Utilization/Risk Adjusted Utilization performance measures.

No opportunities for improvement are identified for the 2021 (MY 2020) Utilization and Risk-Adjusted Utilization performance measures.

While all other measures in the Utilization and Risk-Adjusted Utilization domain were considered reportable for NCQA audit purposes, the results could be reviewed and improvement strategies could be considered, where warranted; further comparisons in subsequent reports (including to applicable benchmarks) can be used for identification of strengths and/or additional opportunities for improvement.

It is recommended that UPMC ensures the SCP issues are addressed for subsequent reporting requirements for MY 2021. This includes addressing care management systems issues to ensure capacity to share care plans for their population.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

For the Adult Medicaid CAHPS, the MCO's survey sample frame was deemed valid by the NCQA-certified auditor.

III: Review of Compliance with Medicaid and CHIP 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 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.

Description of Data Obtained

The documents used by the EQRO for the current review include the SMART database findings, as of the effective review year, per the following: the CHC Agreement, additional monitoring activities outlined by the Department, and the most recent NCQA Accreditation Survey for UPMC. Historically, regulatory requirements were grouped to corresponding BBA regulation subparts based on the Department's on-site review findings. Beginning in 2021, findings are reported by the EQRO using the SMART database completed by the Department's staff. The SMART items provide the information necessary for this review. The SMART items and their associated review findings for this year, which is the first year for CHC, are maintained in a database. The SMART database has been maintained internally at the Department starting with (RY) 2020 and will continue going forward for future review years. The EQRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 59 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations.

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the subparts set out in the BBA regulations that were updated in 2016 and finalized in late 2019. These requirements are described in the CMS EQR Protocol: *Review of Compliance with Medicaid and CHIP Managed Care Regulations*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. The EQRO's findings are presented in a manner consistent with the subparts in the BBA regulations explained in the Protocol, i.e., Subpart D – MCO, Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) Standards and Subpart E – Quality Measurement and Improvement.

The crosswalk links SMART items to specific provisions of the regulations, where possible. Items linked to each standard designated in the protocols as subject to compliance review were included either directly through one of the 11 required standards below, as presented in **Table 3.1** and **Table 3.2**, or indirectly through interaction with Subparts D and E.

Table 3.1: Regulations Directly Crosswalked to SMART

BBA Regulation	Citation
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 systems	438.406
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

SMART: Systematic Monitoring, Access and Retrieval Technology; BBA: Balanced Budget Act; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan.

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- or non-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 UPMC, there were no categories determined to be partially- or non-Compliant, signifying that no SMART Items were assigned a value of non-Compliant by the Department.

Findings

30 items were directly associated with a regulation subject to compliance review and of these, 30 were evaluated for the MCO in Review Year (RY) 2020. Additionally, 29 items were indirectly associated to the regulations and of these, 29 were evaluated for the MCO in RY 2020.

Subpart D: MCO, PIHP and PAHP Standards: the general purpose of the regulations included under this heading is to ensure that all services covered under the Department's CHC program are available and accessible to MCO enrollees. [42 C.F.R. § 438.206 (a)].

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

Table 3.2: MCO Compliance with CFR Categories for Subparts D and E Directly Associated with SMART

MCO, PIHP AND PAHP STANDARDS		
Subpart D: Categories	**Compliance**	**Comments**
Availability of services	Compliant	The MCO was evaluated against 3 items directly associated with this category for RY 2020 and was compliant on all 3 items based on RY 2020.
Assurances of adequate capacity & services	Not Determined	The MCO was evaluated against 0 items directly associated with this category for Ry 2020. Compliance was not determined based on RY 2020.
Coordination & continuity of care	Compliant	The MCO was evaluated against 8 items directly associated with this category for RY 2020 and was compliant on 8 items based on RY 2020.
Coverage & authorization of services	Compliant	The MCO was evaluated against 2 items directly associated with this category for RY 2020 and was compliant on all 2 items based on RY 2020.
Provider selection	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2020 and was compliant on this item based on RY 2020.
Confidentiality	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2020 and was compliant on this item based on RY 2020.
Grievance systems	Compliant	The MCO was evaluated against 2 items and was compliant directly associated with this category for RY 2020 and was compliant on all 2 items based on RY 2020.
Subcontractual relationships & delegation	Compliant	The MCO was evaluated against 2 items directly associated with this category for RY 2020 and was compliant on all 2 items based on RY 2020.
Practice guidelines	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2020 and was compliant on this item based on RY 2020.
Health information systems	Compliant	The MCO was evaluated against 6 items directly associated with this category for RY 2020 and was compliant on all 6 items based on RY 2020.
QUALITY MEASUREMENT AND IMPROVEMENT		
Subpart E: Categories	**Compliance**	**Comments**
Quality assessment & performance improvement program (QAPI)	Compliant	The MCO was evaluated against 4 items directly associated with this category for RY 2020 and was compliant on all 4 items based on RY 2020.

MCO: managed care organization; CFR: Code of Federal Regulations; SMART: Systematic Monitoring, Access and Retrieval Technology; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan.

Summarily, the MCO was found to be compliant across all applicable items directly associated with CFR Categories for Subparts D and E that were subject to review in RY 2020. Additionally, the MCO was found to be compliant/without issue across the items that were indirectly associated with CFR Categories for Subparts D and E that were subject to review in RY 2020.

There are therefore no new recommendations related to compliance with CFR Categories for Subparts D and E for the MCO for the current review year.

IV: MCO's Responses to Previous Opportunities for Improvement

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." In addition to the opportunities identified from the EQR, the Department may request MCOs to develop a root cause analysis around select indicators. **Table 4.1** displays the MCO's opportunities as well as the EQRO's assessment of their responses. The detailed responses are included in the embedded Word document.

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each MCO has addressed the opportunities for improvement made by the EQRO in the 2020 EQR Technical Reports, which were distributed May 2021.

UPMC Response to Previous EQR Recommendations

Table 4.1 displays UPMC's progress related to the *2020 External Quality Review Report,* as well as the EQRO's assessment of UPMC's response.

Table 1: UPMC Response to Previous EQR Recommendations

Recommendation for UPMC	EQRO Assessment of MCO Response[1]
Improve aspects of its interventions to ensure PIP activities are strongly associated with the intended PIP outcomes. The MCO should incorporate any telephonic/telehealth activity and tracking into current or planned interventions since the onset of the COVID-19 pandemic.	Addressed

[1] The EQRO assessments are as follows: **addressed:** MCP'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**: MCP's QI response did not address the recommendation; improvement was not observed, or performance declined.

CHC: Community HealthChoices; EQR: external quality review; EQRO: external quality review organization; MCO: managed care organization.

V: Strengths and Opportunities for Improvement and EQR Recommendations

The review of the MCO's MY 2020 performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for CHC members served by this MCO.

Strengths

- UPMC was found to be fully compliant on all elements reviewed for the Strengthening Care Coordination PIP.

Opportunities for Improvement

- For one Access/Availability of Care performance measure, the MCO was found to have an issue in its capacity to produce a valid measurement. The MCO has been notified of the issue earlier in 2021, and has responded that the provider portal team has been working implementing enhancements necessary to produce a valid measure, and in the most recent communication on this issue it was indicated that the appropriate workflow would be functional for compliance with reporting requirements for MY 2021. Nonetheless, the EQRO recommends that the MCO ensures the SCP issues are addressed for subsequent reporting requirements for MY 2021.

EQR Recommendations

Table 5.1: EQR Recommendations

Measure/Project	EQRO Recommendation	Standards
Performance Improvement Projects (PIPs)		
There are no recommendations related to compliance with PIPs for the MCO for the current review year.		
Performance Measures and CAHPS Survey		
Long-Term Services and Supports: Shared Care Plan	It is recommended that UPMC ensures the SCP issues are addressed for subsequent reporting requirements for MY 2021. This includes addressing care management systems issues to ensure capacity to share care plans for their population.	Timeliness, Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with CFR Categories for Subparts D and E for the MCO for the current review year.		

EQR: external quality review; EQRO: external quality review organization; MCO: managed care organization; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CHIP: Children's Health Insurance Program; CFR: Code of Federal Regulations.

VI: Summary of Activities

This section provides a summary of EQR activities for UPMC for this review period.

Performance Improvement Projects

- As previously noted, the MCO's Strengthening Care Coordination and Transition of Care from the Nursing Facility to the Community PIP submissions were validated. The MCO received feedback and subsequent information related to these activities from the EQRO.

Performance Measurement and CAHPS Surveys

- The MCO produced all HEDIS, PA-Specific, and CAHPS Survey performance measures for MY 2020 for which the MCO had a sufficient denominator; all measures were reported with the exception of the LTSS SCP measure.

Compliance with Medicaid and CHIP Managed Care Regulations

- The MCO was found to be in compliance with CFR Categories for Subparts D and E for the MCO for the current review year.

MCO's Responses to Previous Opportunities for Improvement

- The MCO addressed the previously identified opportunities for improvement for PIPs: the MCO improved aspects of its interventions to ensure PIP activities are strongly associated with the intended PIP outcomes; the MCO also incorporated any telephonic/telehealth activity and tracking into current or planned interventions since the onset of the COVID-19 pandemic.

Strengths and Opportunities for Improvement in Review Year 2021

- Both strengths and opportunities for improvement, as applicable, have been noted for the MCO in 2021. A response will be required by the MCO for the noted opportunities for improvement in 2022.

Appendix

A.1. Performance Improvement Project Interventions

As referenced in **Section I: Validation of Performance Improvement Projects**, **Table A.1** lists all the interventions outlined in the MCO's most recent PIP submission for the review year.

Table A.1: PIP Interventions

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

Summary of Interventions
After notification of the discharge date from the facility, the MCO will enhance coordination to ensure a service plan is set up within 48 hours for participants' visit or telephonic meeting (plus in some regions, further enhance with telephonic integration and monitoring starting in March 2020 due to COVID-19)
After notification of admission to the NF, the SC to begin enhanced discharge planning with the participant within the first 45 days of the NF stay in select regions.
Empower participants and/or families with communication tools/materials to successfully collaborate with the direct care worker/agency to have a positive, constructive, and engaging relationship in select regions.
Enhanced monitoring of participants discharged from PICs to participants residing in NFs not participating in PIC program in select regions.

PIP: performance improvement project; CHC: Community HealthChoices.

A.2. Comprehensive Compliance Standards List

Revised CMS protocols include updates to the structure and compliance standards, including which standards are required for compliance review. Under the most recent protocols, there are 11 standards that CMS has now 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. **Table A.2** lists the standards in the updated protocol, designated as one of the 11 required standards or one of those deemed as a related standard.

Table A.2: Required and Related Structure and Compliance Standards

BBA Regulation	Required	Related
Subpart C: Enrollee Rights and Protections		
Enrollee Rights		✓
Provider-Enrollee Communication		✓
Marketing Activities		✓
Emergency and Post-Stabilization Services – Definition		✓
Emergency Services: Coverage and Payment		✓
Subpart D: MCO, PIHP and PAHP Standards		
Availability of Services	✓	
Assurances of adequate capacity and services	✓	
Coordination and Continuity of Care	✓	
Coverage and Authorization of Services	✓	
Provider Selection	✓	
Provider Discrimination Prohibited		✓
Confidentiality	✓	
Enrollment and Disenrollment		✓
Grievance and appeal Systems	✓	
Subcontractual Relationships and Delegations	✓	
Practice Guidelines	✓	
Health Information Systems	✓	
Subpart E: Quality Measurement and Improvement; External Quality Review		
Quality assessment and performance improvement program (QAPI)	✓	
Subpart F: Grievance and Appeal System		
General Requirements		✓
Notice of Action		✓

BBA Regulation	Required	Related
Handling of Grievances and Appeals		✓
Resolution and Notification		✓
Expedited Resolution		✓
Information to Providers and Subcontractors		✓
Recordkeeping and Recording		✓
Continuation of Benefits Pending Appeal and State Fair Hearings		✓
Effectuation of Reversed Resolutions		✓

BBA: Balanced Budget Act; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan.