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

External Quality Review

Community HealthChoices Managed Care Organization Technical Report for University of Pittsburgh Medical Center (UPMC) Health Plan, January–December 2022

April 7, 2023

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Introduction

Purpose and Background

The final rule of the Balanced Budget Act of 1997 (BBA) 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 MCOs furnish 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 Community HealthChoices (CHC) MCOs. Updated protocols were published in late 2019.

The Pennsylvania (PA) Department of Human Services (DHS) 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.

CHC was phased in over a 3-year period: Phase 1 began January 1, 2018, in the Southwest (SW) 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 (SE) 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 [NW], and Northeast [NE]). Statewide, PA DHS Office of Long-Term Living (OLTL) contracts with MCOs to provide CHC benefits to members.

The final rule of the BBA requires that state agencies contract with an EQRO to conduct an annual EQR of the services provided by the contracted 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 (MMC) 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 (ATR).

The mandatory EQR-related activities that must be included in detailed ATRs, per *Title 42 Code of Federal Regulations (CFR) Section (§) 438.358*, are as follows:

- validation of performance improvement projects (PIPs),
- validation of MCO performance measures (PMs), and
- review of compliance with Medicaid and Children's Health Insurance Program (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, for RY2022 validation of network adequacy was not a mandatory activity and was conducted at the state's discretion. Each managed care program agreement entered into by the PA DHS OLTL 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 2022 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 seven core sections:

I. Performance Improvement Projects
II. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys
III. Review of Compliance with Medicaid and CHIP Managed Care Regulations
IV. Focus Study – Enrollment-Eligibility Data
V. MCO's Responses to Previous Opportunities for Improvement
VI. Strengths, Opportunities for Improvement, and EQR Recommendations
VII. 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 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 PM submissions. PM validation as conducted by the EQRO includes applicable PA-specific PMs as well as Healthcare Effectiveness Data and Information Set (HEDIS®) measures for each MCO. Within **Section II**, CAHPS Survey validation results follow the PMs.

Historically for MCOs, the information for the compliance with Medicaid and CHIP managed care regulations 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 MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from OLTL's contract agreements with each MCO, 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 includes the MCO's results and responses to the 2022 focus study completed by OLTL and the MCO to review enrollment and eligibility data. This section also includes recommendations.

Section V includes the MCO's responses to the *2021 EQR ATR's* opportunities for improvement and presents the degree to which the MCO addressed each opportunity for improvement.

Section VI has a summary of the MCO's strengths and opportunities for improvement for this review period as determined by the EQRO. This section highlights PMs across HEDIS and PA-specific PMs where the MCO has performed highest and lowest. This section also includes EQR recommendations.

Section VII contains a summary of findings across all sections of the EQR ATRs, including PIPs, PMs, compliance with Medicaid and CHIP managed care regulations, MCO's responses to the 2021 recommendations, and the strengths and opportunities for improvement found for 2022.

I: Performance Improvement Projects

Objectives

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

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 2022 (CHC Agreement, 2022). 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 Nursing Facility (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 7-day follow-up behavioral health (BH) 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 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.

For this PIP, MCOs were required to submit rates at the baseline, interim, and final MY 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, and
- 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. 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 reviewed against applicable review elements and associated requirements; first set of elements relates to baseline and demonstrable improvement phases of PIP; and last element relates to sustaining improvement from baseline measurement.

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.

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 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.

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.

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 PI 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: 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.

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. MY 2018 is the initial baseline year, and during the 2022 RY, elements were reviewed at multiple points during the year and scored using the Year 3 annual reports submitted in 2022. 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 presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 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 RY. 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; **Table 2**).

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[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 noted in the scoring matrix (**Table 2**), 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 RY. 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 RY.

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 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. One additional PI for the non-clinical PIP around Transitional Care Planning was implemented in 2022. Two additional PIs for the clinical PIP around Transitional Care Planning and Notification of Discharge were also implemented in 2022. For measurement in the PIP, multiple data sources were allowable, including: MCO pharmacies, service coordinator entities, copayments (e.g., after day 20 for Medicare-covered skilled nursing stays), and traditional long-term care claims. Preliminary measurements were based on participants that were Medicaid-only CHC participants and/or aligned dual eligible special need plan (D-SNP) CHC participants; as PIP implementation expanded, CHC MCOs utilized internal claims while the expansion regions' 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 3 implementation, which were subjected to EQR and scored for reporting the year's PIP compliance determinations, were submitted to the EQRO in March 2022 with updates on interventions through the first half of 2022 submitted to the EQRO in August 2022. Due to data integrity issues in the Year 4 Interim submission, a resubmission was required by the MCO. Despite the resubmission, the MCO received feedback and subsequent information related to these activities from the EQRO.

The following summarizes PIP compliance assessments for the MCO's Annual PIP Reports (Year 3 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 3 implementation review, the MCO scored 100% (80.0 points out of a maximum possible weighted score of 80.0 points). The MCO could limit the denominator for the 7-day follow up after BH discharge PI. Additionally, the MCO could provide details on data quality protocols including but not limited to who oversees the departmental specific protocols, how often data quality assurance is performed, by whom, and how IRR is addressed. If, instead of using the entire participant population, samples are selected (for instances when there are enough eligible participants meeting measure criteria), comprehensive and specific details for "statistically valid random samples" should be reported with consideration to conveying what such validity is based on (e.g., describing estimated frequencies, margins of error, confidence intervals, and specific variables). Finally, the MCO should elaborate on attempts to address relevant barriers in addition to working with the state and other MCOs. The MCO utilized comparable methodology statewide, which accordingly factors 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 3 implementation review, the MCO scored 100% (80.0 points out of a maximum possible weighted score of 80.0 points). The methodology section could be enhanced through further details of the data quality protocols including departmental specific protocols, how often data quality assurance is performed, by whom, and how IRR is addressed. Furthermore, the MCO should elaborate on attempts to address barriers in addition to working with the state and other MCOs. 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 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	Met
Element 7. Discussion and Validity of Reported Improvement	Met	Met

UPMC: UPMC Health Plan; 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%.

II: Performance Measures and CAHPS Surveys

Objective

The EQRO conducted PM validation for each of the MCOs and facilitated associated data collection. IPRO validated all performance measures reported by each MCO for MY 2021 to ensure that the performance measures were implemented to specifications and state reporting requirements (42 C.F.R. § 438.330(b)(2).

Methodology

Starting in December 2021, technical specifications for PMs, 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 2022 measures from the NCQA publication, *HEDIS 2022 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 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.

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

Table 4: Performance Measure Groupings

Source	Measures
Effectiveness of Care	
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)
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)

Source	Measures
HEDIS	Use of Opioids From Multiple Providers (UOP)
HEDIS	Risk of Continued Opioid Use (COU)
HEDIS	Pharmacotherapy for Opioid Use Disorder (POD)
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)
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.

One PA-specific PM was 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 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; 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 that are childhood-related and pregnancy-related, as well as those involving BH (BH 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, 2022: 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., D-SNP enrollment is not aligned with the MCO, or the member has another Medicare Advantage or fee-for-service [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 were 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 sampling frames: a Medicaid Adult CAHPS sampling frame (aligned with the Medicaid IDSS) and a 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 2021 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 1 year would not capture membership in the latest expansion regions for CHC Phase 3 (i.e., NE, NW, Lehigh/Capital regions).

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.

Implementation of PA-Specific Performance Measures and HEDIS Audit

The MCO implemented one of the PA-specific measures for MY 2021, which was reported with MCO-submitted data. 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.

The MCO successfully completed the HEDIS MY 2021 (RY 2022) 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

Table 5 through **Table 8**, below, summarize the MCO's MY 2021 HEDIS and PA EQR PM results, with noteworthy findings listed underneath the table.

In addition to each individual MCO rate, the PA DHS Mean and the CHC MMC Average for 2022 (MY 2021) is presented. The PA DHS Mean does not include measures with denominators less than 30. The CHC MMC Average is a weighted average, which is an average that considers the proportional relevance of each MCO, and therefore includes measures with denominators less than 30.

Effectiveness of Care

Table 5 presents the MCO's HEDIS MY 2021 (RY 2022) PM rates for Effectiveness of Care.

Table 5: HEDIS MY 2021 (RY 2022) Performance Measure Rates for Effectiveness of Care

CHC-MCO HEDIS Measures	UPMC	PA DHS Mean	Weighted Average
Effectiveness of Care			
Prevention and Screening			
Breast Cancer Screening (BCS)			
BCS: Total Rate	63.95%	55.56%	60.27%
Cervical Cancer Screening (CCS)			
CCS: Total Rate	53.28%	44.40%	49.50%
Chlamydia Screening in Women (CHL)			
CHL: Ages 21-24 Years	42.42%	39.55%	40.62%
CHL: Total Rate	42.42%	39.55%	40.62%
Care for Older Adults (COA)			
COA: Advance Care Planning	60.10%	42.58%	51.60%
COA: Medication Review	86.13%	88.02%	87.76%
COA: Functional Status Assessment	72.75%	57.30%	65.76%
COA: Pain Assessment	86.62%	83.09%	85.66%
Respiratory Conditions			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)			
SPR: Total Rate	24.65%	21.72%	23.99%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
PCE: Systemic Corticosteroid	79.06%	75.49%	77.03%
PCE: Bronchodilator	88.93%	90.84%	90.79%
Asthma Medication Ratio (AMR)			
AMR: 19-50 Years	71.43%	63.88%	63.30%
AMR: 51-64 Years	66.46%	55.37%	52.88%
AMR: Total Rate	68.84%	58.59%	56.79%
Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)			
CBP: Total Rate	74.94%	64.97%	67.60%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)			
PBH: Total Rate	93.48%	94.30%	94.25%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
SPC: Received Statin Therapy - 21-75 Years (Male)	86.25%	87.48%	86.91%
SPC: Received Statin Therapy - 40-75 Years (Female)	81.14%	86.07%	84.12%
SPC: Received Statin Therapy - Total Rate	83.52%	86.68%	85.39%
SPC: Statin Adherence 80% - 21-75 Years (Male)	86.33%	79.20%	83.42%
SPC: Statin Adherence 80% - 40-75 Years (Female)	87.88%	84.01%	84.85%
SPC: Statin Adherence 80% - Total Rate	87.13%	81.95%	84.19%
Diabetes			
Comprehensive Diabetes Care (CDC)			
CDC: HbA1c Testing	91.73%	88.44%	89.30%
CDC: HbA1c Poor Control (> 9.0%)	29.20%	37.05%	33.96%
CDC: HbA1c Control (< 8.0%)	62.77%	52.80%	56.28%

CHC-MCO HEDIS Measures	UPMC	PA DHS Mean	Weighted Average
CDC: Eye Exam	74.21%	57.48%	62.54%
CDC: Blood Pressure Controlled (< 140/90 mmHg)	70.32%	60.77%	62.33%
Statin Therapy for Patients with Diabetes (SPD)			
SPD: Received Statin Therapy	77.70%	77.90%	78.02%
SPD: Statin Adherence 80%	85.84%	80.91%	81.95%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (AMM)			
AMM: Effective Acute Phase Treatment	72.97%	73.62%	72.60%
AMM: Effective Continuation Phase Treatment	60.36%	61.85%	60.12%
Diabetes Screening For People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)			
SSD: Total Rate	83.76%	85.00%	83.92%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)			
SMD: Total Rate	76.45%	66.55%	70.69%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)			
SMC: Total Rate	75.61%	72.33%	73.39%
Pharmacotherapy for Opioid Use Disorder (POD)			
POD: Ages 16-64 Years	49.19%	37.92%	42.68%
POD: Ages 65+ Years	59.38%	72.15%	61.29%
POD: Total Rate	50.69%	41.23%	45.22%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
SAA: Total Rate	84.95%	78.86%	80.16%
Overuse/Appropriateness			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
AAB: 18-64 Years	33.11%	44.98%	42.27%
AAB: 65+ Years	23.08%	45.55%	65.06%
AAB: Total Rate	30.54%	46.41%	41.41%
Use of Imaging Studies for Low Back Pain (LBP)			
LBP: Total Rate	76.67%	77.69%	78.30%
Use of Opioids at High Dosage (HDO)			
HDO: Total Rate	8.82%	11.65%	10.58%
Use of Opioids From Multiple Providers (UOP)			
UOP: Multiple Prescribers	17.57%	14.76%	16.07%
UOP: Multiple Pharmacies	2.10%	1.60%	1.84%
UOP: Multiple Prescribers and Multiple Pharmacies	1.09%	0.84%	0.96%
Risk of Continued Opioid Use (COU)			
COU: 18-64 Years - ≥ 15 Days Covered	13.98%	12.60%	13.10%
COU: 65+ Years - ≥ 15 Days Covered	20.05%	16.90%	19.19%
COU: Total Rate - ≥ 15 Days Covered	15.89%	13.60%	14.62%
COU: 18-64 Years - ≥ 31 Days Covered	8.58%	9.76%	9.32%
COU: 65+ Years - ≥ 31 Days Covered	10.93%	10.82%	11.59%
COU: Total Rate - ≥ 31 Days Covered	9.32%	10.13%	9.89%
Medication Management			
Transition of Care (TRC)			
TRC: Notification of Inpatient Admission	51.34%	16.43%	33.81%

CHC-MCO HEDIS Measures	UPMC	PA DHS Mean	Weighted Average
TRC: Receipt of Discharge Information	45.26%	14.01%	29.62%
TRC: Patient Engagement After Inpatient Discharge	89.54%	83.11%	86.13%
TRC: Medication Reconciliation Post-Discharge	73.72%	62.46%	69.24%

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; CHC: Community HealthChoices; MCO: managed care organization; UPMC: UPMC Health Plan; PA DHS: Pennsylvania Department of Human Services.

For the HEDIS MY 2021 (RY 2022) Effectiveness of Care PMs, several measures showed significant improvement. The Asthma Medication Ratio (AMR) for the 51–64 years age group and the total rate exceeded the weighted average by 13.58 percentage points and 12.05 percentage points, respectively. The Controlling High Blood Pressure (CBP) was 7.34 percentage points higher than the weighted average. For the Comprehensive Diabetes Care (CDC) both the Eye Exam and the Blood Pressure Controlled exceeded the weighted average by 11.67 percentage points and 7.99 percentage points, respectively. Finally, regarding the Transitions of Care measure, the Notification of Inpatient Admission was 17.53 percentage points higher than the weighted average.

No opportunities for improvement are identified for the HEDIS MY 2021 (RY 2022) Effectiveness of Care performance measures.

While all HEDIS 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 6 presents the MCO's HEDIS MY 2021 (RY 2022) PM rates for Access/Availability of Care.

Table 6: HEDIS MY 2021 (RY 2022) Performance Measure Rates for Access/Availability of Care

CHC-MCO HEDIS Measures	UPMC	PA DHS Mean	Weighted Average
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
AAP: Ages 20-44 Years	94.33%	91.59%	91.90%
AAP: Ages 45-64 Years	97.75%	96.34%	96.53%
AAP: Ages 65+ Years	96.85%	94.91%	95.82%
AAP: Total Rate	96.90%	95.12%	95.57%
Long-Term Services and Supports			
Comprehensive Assessment and Update (CAU)			
CAU: Assessment of Core Elements	88.50%	78.57%	79.24%
CAU: Assessment of Supplemental Elements	88.50%	78.57%	79.24%
Comprehensive Care Plan and Update (CPU)			
CPU: Care Plan with Core Elements Documented	63.72%	76.01%	75.80%
CPU: Care Plan with Supplemental Elements Documented	63.72%	76.01%	75.80%
Reassessment/Care Plan Update After Inpatient Discharge (RAC)			
RAC: Reassessment After Inpatient Discharge	32.29%	33.34%	33.56%
RAC: Reassessment and Care Plan Update After Inpatient Discharge	17.71%	27.94%	25.59%
Shared Care Plan with Primary Care Practitioner (SCP)			
SCP: Total Rate	54.31%	63.08%	62.24%

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; CHC: Community HealthChoices; MCO: managed care organization; UPMC: UPMC Health Plan; PA DHS: Pennsylvania Department of Human Services.

No strengths were identified for the HEDIS MY 2021 (RY 2022) Access to/Availability of Care PMs.

No opportunities for improvement are identified for the HEDIS MY 2021 (RY 2022) Access to/Availability of Care PMs.

Utilization and Risk-Adjusted Utilization

Table 7 presents the MCO's HEDIS MY 2021 (RY 2022) PM results for Utilization and Risk-Adjusted Utilization. For some Utilization and Risk Adjusted Utilization measurements, the field for weighted average is shaded gray because a weighted average is not applicable for this category of measurement.

Table 7: HEDIS MY 2021 (RY 2022) Performance Measure Results for Utilization and Risk-Adjusted Utilization

CHC-MCO HEDIS Measures	UPMC	PA DHS Mean	Weighted Average
Utilization and Risk Adjusted Utilization			
Utilization			
Frequency of Selected Procedures (FSP)			
FSP: Bariatric Weight Loss Surgery - 20-44 Years - M	0.03	0.05	
FSP: Bariatric Weight Loss Surgery - 20-44 Years - F	0.48	0.29	
FSP: Bariatric Weight Loss Surgery - 45-64 Years - M	0.07	0.06	
FSP: Bariatric Weight Loss Surgery - 45-64 Years - F	0.18	0.20	
FSP: Hysterectomy - Abdominal - 15-44 Years - F	0.14	0.10	
FSP: Hysterectomy - Abdominal - 45-64 Years - F	0.06	0.10	
FSP: Hysterectomy - Vaginal - 15-44 Years - F	0.17	0.13	

CHC-MCO HEDIS Measures	UPMC	PA DHS Mean	Weighted Average
FSP: Hysterectomy - Vaginal - 45-64 Years - F	0.05	0.06	
FSP: Cholecystectomy - Open - 30-64 Years - M	0.05	0.05	
FSP: Cholecystectomy - Open - 15-44 Years - F	0.00	0.01	
FSP: Cholecystectomy - Open - 45-64 Years - F	0.06	0.07	
FSP: Cholecystectomy - Laparoscopic - 30-64 Years - M	0.36	0.26	
FSP: Cholecystectomy - Laparoscopic - 15-44 Years - F	0.59	0.59	
FSP: Cholecystectomy - Laparoscopic - 45-64 Years - F	0.50	0.44	
FSP: Back Surgery - 20-44 Years - M	0.16	0.41	
FSP: Back Surgery - 20-44 Years - F	0.42	0.33	
FSP: Back Surgery - 45-64 Years - M	0.82	0.67	
FSP: Back Surgery - 45-64 Years - F	1.09	0.72	
FSP: Mastectomy - 15-44 Years - F	0.06	0.04	
FSP: Mastectomy - 45-64 Years - F	0.04	0.08	
FSP: Lumpectomy - 15-44 Years - F	0.17	0.10	
FSP: Lumpectomy - 45-64 Years - F	0.27	0.31	
Ambulatory Care: Total (AMBA)			
AMBA: Outpatient Visits	1,110.29	940.06	981.04
AMBA: Emergency Department Visits	82.60	82.62	82.17
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)			
IPUA: Total Discharges	25.56	33.13	
Antibiotic Utilization: Total (ABXA)			
ABXA: Total Antibiotic Scrips	73,893.00	31,557.75	
ABXA: Average Scrips PMPY for Antibiotics	1.91	1.51	
ABXA: Total Number of Scrips for Antibiotics of Concern	33,253.00	13,776.25	
ABXA: Average Scrips PMPY for Antibiotics of Concern	0.86	0.65	
Risk Adjusted Utilization			
Plan All-Cause Readmissions (PCR)			
PCR: Count of Index Stays (Ages 18-44 Years)	334.00	347.25	
PCR: Count of Index Stays (Ages 45-54 Years)	523.00	497.75	
PCR: Count of Index Stays (Ages 55-64 Years)	1,128.00	1,058.50	
PCR: Count of Index Stays (Ages Total)	1,985.00	1,903.50	
PCR: Count of Observed 30-Day Readmissions (Ages 18-44 Years)	30.00	49.00	
PCR: Count of Observed 30-Day Readmissions (Ages 45-54 Years)	56.00	69.00	
PCR: Count of Observed 30-Day Readmissions (Ages 55-64 Years)	125.00	141.75	
PCR: Count of Observed 30-Day Readmissions (Ages Total)	211.00	259.75	
PCR: Count of Expected 30-Day Readmissions (Ages 18-44 Years)	38.95	40.38	
PCR: Count of Expected 30-Day Readmissions (Ages 45-54 Years)	64.49	61.51	
PCR: Count of Expected 30-Day Readmissions (Ages 55-64 Years)	155.39	148.05	
PCR: Count of Expected 30-Day Readmissions (Ages Total)	258.83	249.94	
PCR: Observed Readmission Rate (Ages 18-44 Years)	8.98	13.97	
PCR: Observed Readmission Rate (Ages 45-54 Years)	10.71	13.96	
PCR: Observed Readmission Rate (Ages 55-64 Years)	11.08	13.67	
PCR: Observed Readmission Rate (Ages Total)	10.63	13.80	
PCR: Expected Readmission Rate (Ages 18-44 Years)	11.66	11.74	

CHC-MCO HEDIS Measures	UPMC	PA DHS Mean	Weighted Average
PCR: Expected Readmission Rate (Ages 45-54 Years)	12.33	12.76	
PCR: Expected Readmission Rate (Ages 55-64 Years)	13.78	14.33	
PCR: Expected Readmission Rate (Ages Total)	13.04	13.45	
PCR: Observed to Expected Readmission Ratio (Ages Total)	0.82	1.03	

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; CHC: Community HealthChoices; MCO: managed care organization; UPMC: UPMC Health Plan; PA DHS: Pennsylvania Department of Human Services; gray shading: weighted average is not applicable for this category of measurement.

No strengths were identified for the HEDIS MY 2021 (RY 2022) Utilization/Risk Adjusted Utilization PMs.

No opportunities for improvement are identified for the HEDIS MY 2021 (RY 2022) Utilization and Risk-Adjusted Utilization PMs.

While all other HEDIS 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.

Pennsylvania-Specific Performance Measure

Table 8 presents the MCO's MY 2021 (RY 2022) Pennsylvania-specific HEDIS performance measure result for the Adults' Annual Dental Visit (AADV).

Table 8: PA-Specific MY 2021 (RY 2022) Performance Measure Result for Adults' Annual Dental Visit

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

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; CHC: Community HealthChoices; MCO: managed care organization; UPMC: UPMC Health Plan; PA DHS: Pennsylvania Department of Human Services.

No strengths were identified for the 2022 (MY 2021) PA PM for Adults' Annual Dental Visit.

The Adults' Annual Dental Visit rate of 20.12%, though reportable and in line with PA DHS Mean and Weighted Averages, is considered low and represents an opportunity for improvement.

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 RY, 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 RYs. The EQRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 61 items were identified that were relevant to evaluation of 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 9** and **Table 10**, or indirectly through interaction with Subparts D and E.

Table 9: Regulations Directly Crosswalked to SMART

BBA Regulation	CFR 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 of 1997; CFR: Code of Federal Regulations; 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

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. [*Title 42 CFR § 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 10: MCO Compliance with CFR Categories for Subparts D and E Directly Associated with SMART

MCO Compliance with CFR Categories for Subparts D and E		
MCO, PIHP and PAHP Standards		
Subpart D: Categories	**Compliance**	**Comments**
Availability of services	Compliant	The MCO was evaluated against 8 items directly associated with this category for RY 2021 and was compliant on all 8 items based on RY 2021.
Assurances of adequate capacity & services	Compliant	The MCO was evaluated against 5 items directly associated with this category for RY 2021 and was compliant on this item based on RY 2021.
Coordination & continuity of care	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2021 and was compliant on this item based on RY 2021.
Coverage & authorization of services	Compliant	The MCO was evaluated against 6 items directly associated with this category for RY 2021 and was compliant on all 6 items based on RY 2021.
Provider selection	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2021 and was compliant on this item based on RY 2021.
Confidentiality	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2021 and was compliant on this item based on RY 2021.
Grievance systems	Compliant	The MCO was evaluated against 2 items directly associated with this category for RY 2021 and was compliant on all 2 items based on RY 2021.
Subcontractual relationships & delegation	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2021 and was compliant on this item based on RY 2021.
Practice guidelines	Compliant	The MCO was evaluated against 3 items directly associated with this category for RY 2021 and was compliant on all 3 items based on RY 2021.
Health information systems	Compliant	The MCO was evaluated against 1 item directly associated with this category for RY 2021 and was compliant on this item based on RY 2021.
Quality Measurement and Improvement		
Subpart E: Categories	**Compliance**	**Comments**
Quality assessment & performance improvement program (QAPI)	Compliant	The MCO was evaluated against 5 items directly associated with this category for RY 2021 and was compliant on all 5 items based on RY 2021.

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; RY: review year; yellow shading emphasizes that compliance was not determined.

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 2021. 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 2021.

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: Focus Study – Enrollment-Eligibility Data

Objective

IPRO, in conjunction with OLTL, conducted an enrollment-eligibility data focus study in 2022. The intent of the study is to determine if the MCOs have processes in place to reconcile, store, and maintain the member information received from OLTL and other external sources. The study's goal is to review and assess the CHC MCOs' enrollment-eligibility systems for participants active on December 31, 2021. This study was included in this report as an optional EQR activity that occurred during the RY.

It should also be noted that CHC MCOs are required to submit annual HEDIS measures to the NCQA along with additional PA OLTL regulatory deliverables that require the identification of the member enrollee product lines and LTSS types that are critical to appropriate categorization and reporting. Based on data discrepancies identified through processes of PM validation for producing MY 2019 and MY 2020 rates, IPRO proposed that an encounter data focus study be developed to enhance identification of key data element values with the information provided from the CHC MCOs. For these reasons, a focus study encompassing review of the CHC MCO enrollment eligibility systems was warranted.

There were two major components to the study. First, IPRO proposed for the CHC MCOs to receive a survey to complete that helped further identify and define each CHC MCO's source(s) of enrollment/eligibility data, as well as each CHC MCO's processes in place to reconcile, store, and maintain the member information received from OLTL and other external sources. Second, IPRO proposed for the study methodology to include member-level record reviews, focused on selected data elements related to eligibility/enrollment and member demographics.

Methodology

IPRO developed and distributed a questionnaire to the CHC MCOs. The purpose of the questionnaire was to assist in the identification and definition of each MCO's enrollment-eligibility data source(s), as well as the CHC MCO's processes in place to reconcile, store and maintain the participant information received from OLTL and other external sources.

In addition, the CHC MCOs were requested to submit a participant level enrollment-eligibility study file for all participants active on December 31, 2021. The file submitted would include basic participant demographic information along with CHC enrollee product Line and LTSS Type. See **Table 11** for the file layout for the requested file.

Table 11: CHC Enrollment Eligibility Data Focused Study File Layout

Data Element Name	Length of Field	Anticipated Format/Values
MCO Name	15	
Enrollee Product Line	1	1 - CHC Medicaid plan and companion Medicare D-SNP 2 - CHC Medicaid plan and original fee-for-service Medicare 3 - CHC Medicaid plan plus unaffiliated Medicare D-SNP 4 - CHC Medicaid plan plus Medicare Advantage plan 5 - CHC Medicaid plan only (Medicaid-only group)
Enrollee Last Name	35	
Enrollee First Name	15	
Enrollee Date of Birth	8	YYYYMMDD
Enrollee Recipient ID#	10	Include 10th digit MAID
Enrollee Gender	1	M=Male F=Female
Enrollee ZIP Code	5	5-digit ZIP code Participant's ZIP code as of December 31, 2021

Data Element Name	Length of Field	Anticipated Format/Values
Race	2	Ensure valid and accurate Race values: '01'=African American '03'=American Indian or Alaskan Native '04'=Asian '05'=White '06'=Other or Not Volunteered '07'=Native Hawaiian or Other Pacific Islander '08'=Not Available
Ethnicity	2	Ensure valid and accurate Ethnicity values: '01'=Non-Hispanic '02'=Hispanic '03'=Missing or Not Available
MCO Number	2	See MCO_Number tab
LTSS Type	1	1 - HCBS 2 - NF 3 - Missing or Not Available

Findings

In January 2022, UPMC provided IPRO with the enrollment-eligibility focused study file. IPRO reviewed and compared UPMC's participant level enrollment-eligibility focused study file to a CHC Enrollment with Medicare Types Report provided by OLTL with active enrollment as of December 31, 2021. IPRO identified data element discrepancies. For any discrepant data element values identified through this process, UPMC was requested to provide clarifications and explanations. Based on UPMC's responses, IPRO randomly selected a sample of up to 50 records for each data element of interest, as warranted (marked yellow in **Table 12**). Sampled records were further reviewed and subsequently used to facilitate discussion with UPMC during the remote meeting on April 20, 2022. Remote meeting participants consisted of IPRO, UPMC, and PA OLTL staff.

Comparing the UPMC data file to the state's CHC Enrollment with Medicare Types Report on each data element, discrepancies are identified and the match rates and records numbers for data elements are summarized in **Table 12**.

UPMC responded with descriptions of discrepancies to the subsampling file from IPRO. Discussions in the remote meeting further explained the reasons for discrepancies (**Table 13**).

Table 12: Data Element Discrepancies and Findings

Field Name	Total # of Records	UPMC # Not Match	UPMC % Not Match	UPMC # Match	UPMC % Match
Enrollee Product Line[1]	134,365	18,898	14.06	115,467	85.94
Last Name	134,365	5,570	4.15	128,795	95.85
First Name	134,365	106	0.08	134,259	99.92
Date of Birth (DOB)	134,365	1	0.00	134,364	100
Gender	134,365	2	0.00	134,363	100
ZIP Code	134,365	590	0.44	133,775	99.56
Race[1]	134,365	10,118	7.53	124,247	92.47
Ethnicity[1]	134,365	18,249	13.58	116,116	86.42
MCO#	134,365	12	0.01	134,353	99.99
LTSS Type[1]	134,365	801	0.60	133,564	99.40

[1]Sub-sampling fields.
UPMC: UPMC Health Plan; MCO: managed care organization; LTSS: long-term services and supports.

Table 13: Discrepancies Description and Discussion

Field Name	UPMC Discrepancy Description	Remote Meeting Discussion & Next Steps
Enrollee Product Line	Discrepancy Description: There are different cases, product was assigned as 0-5 which were different from State. UPMC advised that for the product assignment discrepancies, member has corresponding plan with new TPL data. For certain sampled records, UPMC advised that upon further review they agree with the Enrollee Product Line bucket the state identified for the member record.	Remote Meeting Discussion: During the remote meeting, state performed member information searching and UPMC confirmed with screens. 834 files used. There are a couple of issues that were discussed. Global Commercial Issue: Carrier Code plus Policy number is the source code used from OLTL. Timing Issue: Since the focus study period focused on the values assigned to the member records as of December 31, 2021, during the remote meeting it was identified that UPMC's member screens may have reflected revised data element values for the member record. Next Steps: • UPMC advised that logic changes may need to be made with the possible addition of a new bucket being assigned. • UPMC will follow up and review previous records to identify regarding the dates.
LTSS Type	Discrepancy Description: There are different cases, LTSS was assigned as 1-3 which were different from State. UPMC advised that for the LTSS discrepancies, members can be as NF or NFI as of 12/31/21.	Remote Meeting Discussion: During the remote meeting, UPMC demonstrated two of the five discrepant member records on their enrollment screens and confirmed the values provided on the MCO focused study file. Timing Issue: since the focus study period focused on the values assigned to the member records as of December 31, 2021, during the remote meeting it was identified that UPMC's member screens may have reflected revised data element values for the member record.
Ethnicity	Discrepancy Description: UPMC advised that for some of ethnicity discrepancies, members are seen as the ethnicities recorded. For some of other cases, UPMC has a data source that reconciles with the expected values from	Remote Meeting Discussion: During the remote meeting, UPMC demonstrated three of the five discrepant member records on their enrollment screens and confirmed the

Field Name	UPMC Discrepancy Description	Remote Meeting Discussion & Next Steps
	IPRO and can begin leveraging this data source moving forward.	values provided on the MCO focused study file. Next Steps: Follow-up sources checking process for race/ethnicity; State will conduct health risk assessment questionnaire.
Race	Discrepancy Description: UPMC has data source that reconciles with the expected values from IPRO for some cases and can begin leveraging this data source moving forward. Some of other cases could be caused by timing issues.	Remote Meeting Discussion: During the remote meeting, UPMC demonstrated two of the five discrepant member records on their enrollment screens and confirmed the values provided on the MCO focused study file. Next Steps: Follow-up sources checking process for race/ethnicity; State will conduct health risk assessment questionnaire.

UPMC: UPMC Health Plan; OLTL: Office of Long-Term Living; TPL: third-party liability; LTSS: long-term services and supports.

As demonstrated in **Table 12**, the three data elements of interest where most discrepancies can be seen are enrollee product line, race, and ethnicity. Compared to the other data elements, enrollee product line, race, and ethnicity have lower match rates when comparing the UPMC data file to the *CHC Enrollment with Medicare Types Report*. The most discrepancies can be seen with enrollee product line, which has the lowest match percentage of 85.94%, followed by ethnicity, which has a match percentage of 86.42%, and race, which has a match percentage of 92.47%.

Moreover, discrepancy descriptions for each of the data elements of interest (i.e., enrollee product line, race, ethnicity, and LTSS type) can be seen in **Table 13**. UPMC also advised that for the enrollee product line assignment discrepancies, members may have corresponding plans with new third-party liability (TPL) data, which is needed for product line determination, however the contract codes provided to the CHC MCOs are often not specific enough to allow the CHC MCOs to determine and/or distinguish between Medicare Advantage and unaligned D-SNP enrollee product lines.

UPMC advised that for the LTSS discrepancies, members can be assigned as NF or NFI as of December 31, 2021. UPMC advised that for some of the ethnicity discrepancies, members are seen as the ethnicities recorded and based on the daily 834 eligibility file received from OLTL. For some of the other cases related to ethnicity and race discrepancies, UPMC has a data source that reconciles with the expected values from IPRO and can begin leveraging this supplemental data source moving forward. Some of the other race discrepancy cases may have been due to timing issues as well.

Challenges identified with reviewing the discrepant data elements during the focus eligibility study included the following:

- During the remote meeting, it was identified that some of the data element discrepancies were due to a timing issue, since the study period focused on the values assigned to the member records as of December 31, 2021, UPMC's member screens may have reflected revised data element values.
- The daily 834 eligibility file received by the CHC MCOs does not include the following enrollee product line buckets that would need to be determined by the MCOs for reporting purposes:
  - 1 - CHC Medicaid plan and companion Medicare D-SNP
  - 2 - CHC Medicaid plan and original fee-for-service Medicare
  - 3 - CHC Medicaid plan plus unaffiliated Medicare D-SNP
  - 4 - CHC Medicaid plan plus Medicare Advantage plan

- 5 - CHC Medicaid plan only (Medicaid-only group)
- OLTL receives the Medicare contract code and the Plan Benefit Package from CMS via the State Phasedown file, also known as MMA file, and develops the *CHC Enrollment with Medicare Types Report* containing information regarding dual eligibles, but the CHC MCOs are not able to receive these files. The December 2021 *CHC Enrollment with Medicare Types Report* received by OLTL contains members assigned to all the CHC MCOs and not parsed by MCO.

Overall Assessment

Overall, the study findings support ensuring that the 834 files and any other supporting data sources are utilized to the fullest extent in enrollment eligibility processing. From what was observed in UPMC's process flow documentation and description of eligibility data processing, it appears as though the UPMC's systems have the capacity to import and maintain additional data from the state.

Since CHC MCOs report HEDIS and CAHPS on the Medicare/Medicaid MCO level and not at any sub-population category level, it would appear from the study findings that the percentage of discrepancies in enrollee product line classification are insignificant to produce any adverse impact on HEDIS and CAHPS reporting.

However, it appears as though UPMC might benefit from some guidance on modifying existing workflows to import data more successfully.

Recommendations

In view of the study findings and overall assessment, IPRO therefore has the following recommendations for the CHC MCOs:

- IPRO recommends UPMC utilizes TPL data to identify the enrollee product line. The CHC MCOs should ensure that they bring in all TPL information from the 834 files, including the carrier codes, family placement code and waiver county code. During the remote meeting UPMC advised and agreed that, with further research and incorporation of the TPL data, UPMC's enrollee product line would match OLTL's value.
- IPRO recommends the CHC MCOs utilize the daily 834 eligibility file to identify the enrollee product line, the 500 series carrier codes should be used to identify that the participant has a Medicare Advantage carrier. However, the carrier code would not be able to identify whether the participant has a D-SNP Medicare Advantage product. The CHC MCOs will need additional information to identify the enrollee product line and could, for example, coordinate with the D-SNP carrier to determine if the Medicare Advantage product that the participant is assigned is a D-SNP or a traditional Medicare Advantage.
- IPRO recommends that the CHC MCOs leverage the data sharing arrangements and relationships with each of the carriers that have a D-SNP plan in PA. The CHC MCOs have a listing of the carriers that offer a D-SNP product, and they should establish data sharing arrangements with each of the D-SNP carriers to assist in identifying a decision on the unaligned D-SNP participants.
- OLTL's HEDIS member-level data reports utilize race and ethnicity values to identify geographic race and ethnicity disparities for certain HEDIS measures. IPRO recommends UPMC leverage all sources to identify an accurate race and ethnicity value for each participant.

V: 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 14** displays the MCO's opportunities and 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 2021 EQR ATRs, which were distributed May 2022.

UPMC Response to Previous EQR Recommendations

Table 14 displays UPMC's progress related to the *2021 External Quality Review Report,* as well as the EQRO's assessment of UPMC's response.

Table 14: UPMC Response to Previous EQR Recommendations

Recommendation for UPMC	EQRO Assessment of MCO Response[1]
Ensure that the SCP issues are addressed for subsequent reporting requirements for MY 2021 for the Long-Term Services and Supports: Shared Care Plan measure. This includes addressing care management systems issues to ensure capacity to share care plans for their population.	Addressed

[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.
UPMC: UPMC Health Plan; CHC: Community HealthChoices; EQR: external quality review; EQRO: external quality review organization; MCO: managed care organization; SCP: shared care plan; MY: measurement year.

VI: Strengths, Opportunities for Improvement, and EQR Recommendations

The review of the MCO's MY 2021 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

- The MCO performed significantly well when compared to the weighted averages for several HEDIS measures from the Effectiveness of Care domain.
    - Asthma Medication Ratio (AMR) for the 51–64 years age group and the total rate exceeded the weighted average by 13.58 percentage points and 12.05 percentage points, respectively.
    - Controlling High Blood Pressure (CBP) was 7.34 percentage points higher than the weighted average.
    - Comprehensive Diabetes Care (CDC) both the Eye Exam and the Blood Pressure Controlled exceeded the weighted average by 11.67 percentage points and 7.99 percentage points, respectively.
    - Transitions of Care - Notification of Inpatient Admission was 17.53 percentage points higher than the weighted average.

Opportunities for Improvement

- The MCO was partially compliant with PIP requirements. The MCO submitted their interim reports in accordance with the submission schedule but discovered data integrity issues that required a resubmission. It is recommended that the MCO improve data reporting capabilities to ensure accurate data is reported for PIP validation in accordance with the submission schedule.
- The Adults' Annual Dental Visit rate, though reportable and in line with PA DHS Mean and Weighted Averages, is considered low and represents an opportunity for improvement.

EQR Recommendations

Table 15 displays EQR recommendations and includes applicable projects, measures, and standards.

Table 15: EQR Recommendations

Project/Measure	EQR Recommendation	Standards
Performance Improvement Projects		
July 2022 PIP Submissions for Strengthening Care Coordination and Transition of Care from Nursing Facility to the Community	It is recommended that the MCO improve data reporting capabilities to ensure accurate data is reported for PIP validation in accordance with the submission schedule.	Timeliness, Quality Outcomes
Performance Measures and CAHPS Survey		
PA-Specific Performance Measure Validation	It is recommended that the MCO work on improving their rate for the PA-specific performance measure, Adults' Annual Dental Visit.	Access to Services
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 RY.		

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

VII: 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 (Year 4 Interim) submissions were submitted in accordance with the submission schedule with data integrity issues that required a resubmission. Despite the resubmission, the MCO received feedback and subsequent information related to these activities from the EQRO.

Performance Measurement and CAHPS Surveys

- The MCO produced all HEDIS and CAHPS Survey performance measures for MY 2021 for which the MCO had a sufficient denominator; all measures were reportable.

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.

Focus Study – Enrollment-Eligibility Data

- The MCO was provided with several recommendations following the focus study to improve their enrollment and eligibility data viability for reporting.

MCO's Responses to Previous Opportunities for Improvement

- The MCO addressed the previously identified opportunities for improvement for ensuring the capacity to share care plans for their population through their care management systems for the Long-Term Services and Supports: Shared Care Plan measure.

Strengths and Opportunities for Improvement in Review Year 2022

- Both strengths and opportunities for improvement, as applicable, have been noted for the MCO in 2022. A response will be required by the MCO for the noted opportunities for improvement in 2023.

Appendix

A1 Performance Improvement Project Interventions

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

Table A1: 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 days of receiving notification of discharge (plus enhancements to expedited SC outreach, i.e., within 1 business day, within certain Regions).
Reduce failed discharges: the care manager attempts outreach to the participant at time of transition of care to provide aspects of care collaboration to meet the participant's needs, such as proactive discharge planning and readmission prevention, scheduling appointments, or connecting the participant to their service coordinator.
Standardization and timeliness (after discharge from an inpatient stay to home when participants are likely to need support for making and attending appointments, or other supports with ADLS and IADLs (plus enhancements to expedited and timely SC outreach within certain Regions).
Enhance the notification of admission process by utilizing EVV data.
Educate providers at high-volume PCP practices on the CHC population and provider expectations through meetings with UPMC Physician Account Executives (PAEs).
Enhance service coordination and care management in the NE, NW, and L/C Regions: ensure that the participant has a scheduled appointment with a practitioner following an inpatient discharge; review the participant's medications post-discharge; and assure the participant has the necessary medications and assist in obtaining the medications if necessary.
Engage the health systems in the L/C Region in involve UPMC in discharge planning to achieve successful transitions of care participants.
UPMC – Transitions of Care
Monitor participants in the SW Region discharged from PICs to participants residing in NFs not participating in PIC program.
Notification system for NFs to notify the MCO (and vice-versa) within 1 business day of participants desiring to transition to the community.
Enhanced meetings between the MCO service coordination and NF participant via quarterly visit to determine if they desire to transition home. Starting in March 2020 due to COVID-19, telephonic meetings integrated and monitored.
Enhanced service coordination by MCO to contact the participant within 1 business day to start the transition process.
After notification of the discharge date from the facility, the MCO will visit the participant in the home within 48 hours (plus in some regions, enhance with telephonic integration and monitoring starting in March 2020 due to COVID-19).
After notification of the discharge date from the facility, the MCO will enhance coordination to ensure services are set up prior to the transition date within 48 hours for participants (plus in some regions, enhance with telephonic integration and monitoring starting in March 2020 due to COVID-19).
After notification of the discharge date from the facility, the MCO will enhance coordination to ensure a service plan is set up within 48 hours for participants' visit or telephonic meeting (plus in some regions, further enhance with telephonic integration and monitoring starting in March 2020 due to COVID-19).

Summary of Interventions
After notification of admission to the NF, the SC to begin enhanced discharge planning with the participant within the first 45 days of the NF stay in select regions.
Empower participants and/or families with communication tools/materials to successfully collaborate with the direct care worker/agency to have a positive, constructive, and engaging relationship in select regions.
Enhanced monitoring of participants discharged from PICs to participants residing in NFs not participating in PIC program in select regions.

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

A2 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 2019 CMS 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 A2** 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 A2: 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		✓
Handling of Grievances and Appeals		✓
Resolution and Notification		✓

BBA Regulation	Required	Related
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 of 1997; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan.