Commonwealth of Pennsylvania
Department of Human Services
2021 External Quality Review Report
Statewide Medicaid Managed Care Annual Report

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Overview

This report is a summary of Medicaid and CHIP managed care (MMC) external quality review (EQR) findings for the Commonwealth of Pennsylvania's behavioral health (BH), physical health (PH), Children's Health Insurance Program (CHIP), Community HealthChoices (CHC) managed care organizations (MCOs), and the Adult Community Autism Program (ACAP) Prepaid Inpatient Health Plan (PIHP). ACAP is currently a small program, with 181 members enrolled as of December 2020, and EQR findings for this program are presented in a separate section within this report.

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

The Pennsylvania (PA) Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) oversees the PH component of the HealthChoices Program. DHS OMAP contracts with PH-MCOs to provide physical health care services to recipients.

DHS's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the behavioral health (BH) component of the HealthChoices Program. OMHSAS determined that the Pennsylvania county governments would be offered "right of first opportunity" to enter into capitated contracts with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program, the mandatory managed care program that provides Medical Assistance (i.e., Medicaid) recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. Through these BH-MCOs, recipients receive mental health and/or drug and alcohol services.

Starting in 1997, the HealthChoices Program was implemented for PH and BH services using a zone phase-in schedule. The zones originally implemented were:

- **Southeast Zone** - Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties;
- **Southwest Zone** - Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington, and Westmoreland Counties; and
- **Lehigh/Capital Zone** - Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York Counties.

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

Starting in July 2006, the HealthChoices BH Program began statewide expansion on a zone phase-in schedule, incorporating additional zones to the original three listed above. The Northeast region's BH implementation went into effect in July 2006, followed by two North/Central implementations. The first North/Central implementation is a directly held state contract that covers 23 counties implemented in January 2007, followed by the second implementation of 15 counties that exercised the right of first opportunity and were implemented in July 2007. The counties included in each of these zones are indicated below:

- **Northeast Zone** - Lackawanna, Luzerne, Susquehanna, and Wyoming Counties;

- **North/Central Zone – State Option** - Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties; and
- **North/Central Zone – County Option** - Bedford, Blair, Cambria, Carbon, Clinton, Crawford, Erie, Fulton, Franklin, Lycoming, Mercer, Monroe, Pike, Somerset, and Venango Counties.

All Pennsylvania counties were covered by the HealthChoices PH Program in 2014, when it became mandatory statewide. For PH services in 2020, Medical Assistance enrollees had a choice of three to five PH-MCOs within their county (depending on the zone of residence).

The PH MCOs that were participating in the HealthChoices PH Program as of December 2020 were:

Physical Health MCOs

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

AmeriHealth Caritas Pennsylvania (ACP) merged with AmeriHealth Caritas Northeast (ACNE) effective 1/1/2021. The change impacted MY 2020, as for HEDIS reporting, AmeriHealth was approved by NCQA to report one Medicaid IDSS for AmeriHealth Caritas (combined ACP and ACNE). Additionally, ACP was treated as a new entity. Therefore, MY 2020 HEDIS data were not compared to prior years' HEDIS data. All PH PA PMs were addressed in the same manner, with no year-to-year comparison for ACP.

Effective 1/1/2022, Gateway Health Plan will be doing business as Highmark Wholecare. Because the plan conducted business as Gateway Health Plan for the review period covered by this report 1/1/2020-12/31/2020, the Gateway name is used for this report.

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

The BH-MCOs that were participating in the HealthChoices BH Program as of December 2020 were:

Behavioral Health MCOs

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

Pennsylvania's Children's Health Insurance Program (CHIP) was established through passage of Act 113 of 1992, reenacted as an amendment to The Insurance Company Law of 1921 by Act 68 of 1998, amended by Act 136 of 2006, and amended and reauthorized by Act 74 of 2013 and Act 84 of 2015 (the Act), and as amended by Act 58 of 2017. It has long been acknowledged as a national model, receiving specific recognition in the Federal Balanced Budget Act of 1997 as one of only three child health insurance programs nationwide that met Congressional specifications.

In early 2007, after passage of Act 136 of 2006, Pennsylvania received approval from the federal government to expand eligibility for CHIP through the Cover All Kids initiative. As of March 2007:

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

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

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

that are licensed and regulated by the Department of Human Services and have contracts with the Commonwealth to offer CHIP coverage. Approximately 149,000 children and teens were enrolled in PA CHIP as of November 2021.

CHIP-MCOs

- Aetna Better Health (ABH),
- Capital Blue Cross (CBC),
- Geisinger Health Plan (GEI),
- Highmark HMO,
- Highmark PPO,
- Health Partners Plan (HPP),
- Independence Blue Cross (IBC),
- First Priority Health (NEPA),
- United Healthcare Community Plan (UHC), and
- UPMC for Kids (UPMC).

The PA DHS Office of Long-Term Living (OLTL) oversees Community HealthChoices (CHC), which is PA's mandatory managed care program for LTSS. CHC is for adults aged 21 years and over, dually-eligible for Medicare and Medicaid, and for older adults, and adults with physical disabilities, in need of long-term services and supports (LTSS). LTSS includes services and supports in the nursing facility setting, as well as the home and community setting to 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 being phased in over a three year period: Phase 1 began January 1, 2018 in the Southwest region (Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties); Phase 2 began January 1, 2019, in the Southeast region (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties); and Phase 3 began January 1, 2020, in the remaining part of the state (Northeast [NE], Northwest [NW], and Lehigh Capital [L/C] Regions). Statewide, PA DHS OLTL contracts with CHC-MCOs to provide CHC benefits to members.

The CHC-MCOs that were participating in CHC as of December 2020 were:

Community HealthChoices MCOs

- AmeriHealth Caritas Pennsylvania (ACP CHC)/Keystone First (KF CHC)[1],
- Pennsylvania Health & Wellness (PAHW), and
- University of Pittsburgh Medical Center Health Plan (UPMC CHC).

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

[1] ACP CHC/KF CHC are affiliated under a single, parent CHC MCO.

Introduction and Purpose

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an external quality review organization (EQRO) to conduct an annual EQR of the services provided by contracted Medicaid MCOs. This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a MCO furnishes to Medicaid recipients.

The EQR-related activities that must be included in the detailed technical reports, per 42 CFR §438.358 (cross walked to §457.1250 for CHIP), are validation of performance improvement projects, validation of MCO performance measures, and review to determine MCO compliance with Medicaid and CHIP managed care regulations established by the state. 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.

DHS contracted with Island Peer Review Organization (IPRO) as its EQRO to conduct the 2021 (MY 2020) EQRs for the Medicaid and CHIP MCOs.

Information Sources

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

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

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

Acronym	Description
C	Compliant
P	Partially compliant
NC	Not compliant
ND	Not determined
NA	Not applicable

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

Section I: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of PIPs for each Medicaid MCO. According to CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (Updated: *Validating Performance Improvement Projects, Final Protocol, Version 2.0, September* 2012) and meets the requirements of the updated final rule on External Quality Review (EQR) of Medicaid Managed Care Organizations issued on May 6, 2016. IPRO's review evaluates each project against 10 elements:

1. Project Topic and Topic Relevance,
2. Study Question (Aim Statement),
3. Study Variables (Performance Indicators),
4. Identified Study Population,
5. Sampling Methods,
6. Data Collection Procedures,
7. Improvement Strategies (Interventions),
8. Interpretation of Study Results (Demonstrable Improvement),
9. Validity of Reported Improvement, and
10. Sustainability of Documented Improvement.

The first nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. IPRO's scoring for each element is based on full, partial, and non-compliance status. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.

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

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

Overall Project Performance Score

For divisions for which weighted scoring is applicable, the total points earned for each review element are weighted to determine the MCO's overall performance score for a PIP. 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).

PIPs also are reviewed for the achievement of sustainability of documented improvement. This has a weight of 20%, for a possible maximum total of 20 points. The MCO must sustain improvement relative to baseline after achieving demonstrable improvement.

Scoring Matrix

For PH, BH, CHC, and CHIP, when the PIPs are reviewed, all projects are evaluated for the same elements according to the timeline established for that PIP. For all PIPs, the scoring matrix is completed for those review elements where activities have occurred in the review year. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of met, partially met, or not met. Elements receiving a finding of met will receive 100% of the points assigned to the element, partially met elements will receive 50% of the assigned points, and not met elements will receive 0% of the assigned points.

As part of the new EQR PIP cycle that was initiated for all CHIP-MCOs in 2017, for all CHC-MCOs in 2018, and for all BH-MCOs and PH-MCOs in 2020, IPRO adopted the LEAN methodology, including re-developed templates for submission and evaluation. These updated methodologies, including how review elements are grouped, are further described in these programs' PIP Review subsections, below.

PH-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each Medicaid PH-MCO. For the purposes of the EQR, PH-MCOs were required to participate in studies selected by OMAP for validation by IPRO in 2021 for 2020 activities. Under the applicable HealthChoices Agreement with the DHS in effect during this review period, Medicaid PH-MCOs are required to conduct focused studies each year. For all PH-MCOs, two PIPs were initiated as part of this requirement in 2020 and continued in 2021. For all PIPs, PH-MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the EQR PIP cycle for all PH-MCOs in 2021, PH-MCOs were required to report on two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: "Preventing Inappropriate Use or Overuse of Opioids" and "Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits."

"Preventing Inappropriate Use or Overuse of Opioids" was selected in light of the of the growing epidemic of accidental drug overdose in the United States, which is currently the leading cause of death in those under 50 years old living in the United States. In light of this, governmental regulatory agencies have released multiple regulatory measures and societal recommendations in an effort to decrease the amount of opioid prescriptions. PA DHS has sought to implement these measures as quickly as possible to impact its at-risk populations. While these measures are new and there is currently little historical data on these measures as of 2020, it remains a priority that future trends are monitored. MCOs were encouraged to develop aim statements for this project that look at preventing overuse/overdose, promoting treatment options, and stigma-reducing initiatives. Since the HEDIS Risk of Continued Opioid Use (COU) and CMS Adult Core Set Concurrent Use of Opioids and Benzodiazepines (COB) measures were first-year measures in 2019, a comparison to the national average was not available at project implementation. However, in PA, Use of Opioids at High Dosage (HDO) was found to be better than the national average for 2019, while Use of Opioids from Multiple Providers (UOP) was worse. The HEDIS UOP measure was worse than the national average for all three indicators: four or more prescribers, four or more pharmacies, and four or more prescribers and pharmacies.

In addition to increased collection of national measures, DHS has implemented mechanisms to examine other issues related to opioid use disorder (OUD) and coordinated treatment. In 2016, the governor of PA implemented the Centers of Excellence (COE) for Opioid Use Disorder program. Prior to COE implementation, 48% of Medicaid enrollees received OUD treatment, whereas after one year of implementation, 71% received treatment. Additionally, the DHS

Quality Care Hospital Assessment Initiative, which focuses on ensuring access to quality hospital services for Pennsylvania Medical Assistance (MA) beneficiaries, was reauthorized in 2018 and included the addition of an Opioid Use Disorder (OUD) incentive. The incentive, based on follow up within 7 days for opioid treatment after a visit to the emergency department (ED) for opioid use disorder, allows hospitals the opportunity to earn incentives by implementing defined clinical pathways to help them get more individuals with OUD into treatment. The DHS also worked with the University of Pittsburgh to analyze OUD treatment, particularly MAT, for PA Medicaid enrollees. Among the findings presented in January 2020 were that the number of Medicaid enrollees receiving medication for OUD more than doubled from 2014-2018, and that the increase was driven by office-based prescriptions for buprenorphine or naltrexone, was seen for nearly all demographic sub-groups, and was higher for rural areas. Similarly, under the Drug and Treatment Act (DATA), prescription rates for buprenorphine have increased. This act allows qualifying practitioners to prescribe buprenorphine for OUD treatment from 30 up to 275 patients and is another component of DHS' continuum of care.

Because opioid misuse and abuse is a national crisis, and due to the impact this has had particularly on PA, the new PH PIP is centered on opioids in the following four common outcome objectives: opioid prevention, harm reduction, coordination/facilitation into treatment, and increase medicated-assisted treatment (MAT) utilization. For this PIP, the four outcome measures discussed above will be collected and in consideration of the initiatives already implemented in PA, three process-oriented measures related to these initiatives will also be collected, focusing on the percentage of individuals with OUD who get into MAT, the duration of treatment for those that get into MAT, and follow-up after an emergency department (ED) visit for OUD. MCOs will define these three measures for their PIPs.

For this PIP, OMAP has required all PH MCOs to submit the following measures on an annual basis:

- Use of Opioids at High Dosage (HDO – HEDIS)
- Use of Opioids from Multiple Providers (UOP – HEDIS)
- Risk of Continued Opioid Use (COU – HEDIS)
- Concurrent Use of Opioids and Benzodiazepines (COB – CMS Adult Core Set)
- Percent of Individuals with OUD who receive MAT (MCO-defined)
- Percentage of adults > 18 years with pharmacotherapy for OUD who have (MCO-defined):
    - at least 90 and;
    - 180 days of continuous treatment
- Follow-up treatment within 7 days after ED visit for Opioid Use Disorder (MCO-defined)

Additionally, MCOs are expected to expand efforts to address health disparities in their populations. MCOs were instructed to identify race and ethnicity barriers and identify interventions that will be implemented to remediate the barriers identified.

"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits" was selected again due to several factors. General findings and recommendations from the PA Rethinking Care Program (RCP) – Serious Mental Illness (SMI) Innovation Project (RCP-SMI) and Joint PH/BH Readmission projects, as well as overall statewide readmission rates and results from several applicable HEDIS and PA Performance Measures across multiple years have highlighted this topic as an area of concern to be addressed for improvement. For the recently completed Readmissions PIP, several performance measures targeted at examining preventable hospitalizations and ED visits were collected, including measures collected as part of the PH-MCO and BH-MCO Integrated Care Plan (ICP) Program Pay for Performance Program, which was implemented in 2016 to address the needs of individuals with serious persistent

mental illness (SPMI). From PIP reporting years 2016 to 2019, results were varied across measures and MCOs. Additionally, from 2017 to 2019, the ICP performance measures targeting the SPMI population showed inconsistent trends and little to no improvement in reducing hospitalizations and ED visits.

Research continues to indicate multiple factors that can contribute to preventable admissions and readmissions as well as the link between readmissions and mental illness. Additionally, within PA, there are existing initiatives that lend themselves to integration of care and targeting preventable hospitalizations, and can potentially be leveraged for applicable interventions. The Patient-Centered Medical Home (PCMH) model of patient care, which focuses on the whole person, taking both the individual's PH and BH into account, has been added to the HealthChoices Agreement. The DHS Quality Care Hospital Assessment Initiative focuses on ensuring access to quality hospital services for PA MA beneficiaries. Under this initiative, the Hospital Quality Incentive Program (HQIP) builds off of existing DHS programs: MCO P4P, Provider P4P within HealthChoices PH, and the ICP Program. It focuses on preventable admissions and provides incentives for annual improvement or against a state benchmark.

Given the PA DHS initiatives that focus on coordination and integration of services and the inconsistent improvement on several metrics, it has become apparent that continued intervention in this area of healthcare for the HealthChoices population is warranted. MCOs were encouraged to develop aim statements for this project that look at reducing potentially avoidable ED visits and hospitalizations, including admissions that are avoidable initial admissions and readmissions that are potentially preventable.

For this PIP, OMAP has required all PH MCOs to submit the following core measures on an annual basis:

- Ambulatory Care (AMB): ED Utilization (HEDIS)
- Inpatient Utilization—General Hospital/Acute Care (IPU): Total Discharges (HEDIS)
- Plan All-Cause Readmissions (PCR – HEDIS)
- PH MCOs were given the criteria used to define the SPMI population, and will be collecting each of the following ICP measures using data from their own systems:
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (MCO Defined)
    - Emergency Room Utilization for Individuals with SPMI (MCO Defined)
    - Inpatient Admission Utilization for Individuals with SPMI (MCO Defined)
    - Adherence to Antipsychotic Medications for Individual with Schizophrenia (MCO Defined)
    - Inpatient 30-Day Readmission Rate for Individuals with SPMI (MCO Defined)

Additionally, MCOs are expected to expand efforts to address health disparities in their populations. MCOs were instructed to identify race/ethnicity barriers and identify interventions that will be implemented to remediate the barriers identified.

These PIPs will extend from January 2019 through December 2022. With research beginning in 2019, initial PIP proposals were developed and submitted in third quarter 2020, with a final report due in October 2023. The non-intervention baseline period was January 2019 to December 2019. Following the formal PIP proposal, the timeline defined for the PIPs includes interim reports in October 2021 and October 2022, as well as a final report in October 2023. For the current review year, 2021, interim reports were due in October. These interim reports underwent initial review by IPRO and feedback was provided to plans, with a timeline to resubmit to address areas of concern.

The 2021 EQR is the eighteenth year to include validation of PIPs. For each PIP, all PH MCOs shared the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions, and timeliness.

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

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

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

To encourage MCOs to focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the PH-MCOs, and IPRO continued and progressed throughout the review year. **Tables 1a** and **1b** summarize PIP compliance assessments across MCOs.

Table 1a: PH-MCO PIP Review Score – Preventing Inappropriate Use or Overuse of Opioids

Project 1 - Improving Access to Pediatric Preventive Dental Care	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic	C	P	P	C	C	P	P	C	P
2. Methodology	C	P	P	C	C	P	P	C	P
3. Barrier Analysis, Interventions, and Monitoring	C	P	P	P	C	P	P	C	P
4. Results	C	P	P	C	C	P	P	C	P
5. Discussion	C	P	NC	P	C	P	P	C	P
6. Next Steps	NA	NA	NA	NA	NA	NA	NA	NA	NA
7. Validity and Reliability of PIP Results	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 1b: PH-MCO PIP Review Score – Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits

Project 2 - Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
1. Project Topic	C	P	P	C	C	P	C	C	P
2. Methodology	C	P	P	C	C	P	P	C	P

3. Barrier Analysis, Interventions, and Monitoring	C	P	P	P	C	P	P	C	P
4. Results	C	P	P	C	C	P	P	C	P
5. Discussion	C	NC	NC	P	C	NC	C	C	P
6. Next Steps	NA	NA	NA	NA	NA	NA	NA	NA	NA
7. Validity and Reliability of PIP Results	NA	NA	NA	NA	NA	NA	NA	NA	NA

CHIP-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each CHIP MCO. For the purposes of the EQR, CHIP MCOs were required to participate in studies selected by DHS CHIP for validation by IPRO in 2017 for 2021 activities. Under the applicable Agreement with DHS in effect during this review period, CHIP MCOs are required to conduct focused studies each year. For all CHIP MCOs, two new PIPs were initiated as part of this requirement in 2018. For all PIPs, CHIP MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the new EQR PIP cycle that was initiated for all CHIP MCOs in 2017, IPRO adopted the Lean methodology, following the CMS recommendation that Quality Improvement Organizations (QIOs) and other healthcare stakeholders embrace Lean in order to promote continuous quality improvement in healthcare. MCOs were provided with the most current Lean PIP submission and validation templates at the initiation of the PIP.

2021 is the thirteenth year to include validation of PIPs. For each PIP, all CHIP MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS CHIP provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions, and timeliness.

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

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

For this PIP, DHS CHIP is requiring all CHIP Contractors to submit rates at the baseline, interims, and final measurement years for the Developmental Screening in the First Three Years of Life CMS Child Core set measure. Additionally, Contractors are encouraged to consider other performance measures such as:

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

"Improving Blood Lead Screening Rates in Children 2 Years of Age" was selected as the result of a number of observations. Despite an overall decrease over the last 30 years in children with elevated blood lead levels in the United States, children from low-income families in specific states, including Pennsylvania, have seen decreased rates of screening of blood lead levels. Current CHIP policy requires that all children ages one and two years old and all children ages 3 through 6 years without a prior lead blood test have blood levels screened consistent with current Department of Health and CDC standards. Using the HEDIS Lead Screening measure, the average national lead screening rate in 2016 was 66.5%, while the Pennsylvania CHIP average was 53.2%. Despite an overall improvement in lead screening rates for Pennsylvania CHIP Contractors over the previous few years, rates by Contractor and weighted average fell below the national average. In addition to the HEDIS lead screening rate, Contractors have been encouraged to consider these measures as optional initiatives:

- Percentage of home investigations where lead exposure risk hazards/factors were identified,
- Total number of children successfully identified with elevated blood lead levels,
- Percent of the population under the age of 5 years suffering from elevated blood lead levels, or
- Percent of individuals employed in the agriculture, forestry, mining, and construction industries.

The PIPs extend from January 2017 through December 2020; with research beginning in 2017, initial PIP proposals developed and submitted in second quarter 2017, and a final report due in June 2021. The non-intervention baseline period is January 2017 to December 2017. Following the formal PIP proposal, the timeline defined for the PIPs includes required interim reports in 2019 and 2020, as well as a final report in June 2021. In adherence with this timeline, all MCOs submitted their final reports in July 2021, with review and findings administered by IPRO in Fall and Winter 2021.

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

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

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

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

The first six elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to summarizing information surrounding the PIP and assessing sustained improvement from the baseline measurement, including whether significant sustained improvement over the lifetime of the project occurred.

To encourage MCOs to focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the CHIP MCOs, and IPRO continued and progressed throughout the review year. **Tables 2a** and **2b** summarize PIP compliance assessments across MCOs.

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

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

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

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

BH-MCO PIP Review

In 2019, OMHSAS directed IPRO to complete a preliminary study of substance use disorders (SUD) in the Commonwealth preliminary to selection of a new PIP topic. As a result, OMHSAS selected the topic, "Successful Prevention, Early Detection, Treatment, and Recovery for Substance Use Disorders" as a PIP for all BH-MCOs in the State. The PIP will extend from 2021 through 2023, including a final report due in 2024. While the topic is common to Primary Contractors and BH-MCOs, each project is developed as a collaboration and discussion between Primary Contractors and their contracted BH-MCOs. Primary Contractors and BH-MCOs were directed to begin conducting independent analyses of their data and partnering to develop relevant interventions and intervention tracking measures. BH-MCOs will be responsible for coordinating, implementing, and reporting the project.

The Aim Statement for this PIP is: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

OMHSAS selected three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an Opioid and/or other SUD;
2. Improve retention in treatment for members with an Opioid and/or other SUD diagnosis;
3. Increase concurrent use of Drug & Alcohol counseling in conjunction with Pharmacotherapy (Medication-Assisted Treatment); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH Contracting networks. The two "activities" may fall under a single intervention or may comprise two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP lens to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

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

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[i] It contains two sub measures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure measures discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended here to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" includes detox episodes only.
3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure uses the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical stage. For this measure, "readmission" is defined as any acute inpatient admission with a primary MH diagnosis, as defined by the PA-specific FUH measure, occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.
4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services as well as

pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[ii] This measure is adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.

5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe Alcohol Use Disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD and targets members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

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

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

- Project Topic/Rationale
- Aim
- Methodology
- Barrier Analysis
- Robust Interventions
- Results
- Discussion and Validity of Reported Improvement
- Sustainability

MCOs submitted initial proposals in September 2020 using an initial baseline period for the five performance indicators of July 1, 2019 through June 30, 2020. MCOs. All five MCO proposals underwent several review iterations and were finally approved for implementation by the first quarter of 2021. In 2021, the PIP project was renamed with the support of the BH-MCOs and Primary Contractors to be, "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders" in accordance with feedback received by the BH-MCOs and Primary Contractors during the first year of the PIP.

In order to establish a calendar year cycle, MCOs were required to recalculate baselines using the full CY 2020 and recalibrate PIP interventions accordingly. Proposals were successfully resubmitted in September 2021. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline. **Table 3** summarizes the findings of the review of proposals after baseline re-run.

Table 3: BH-MCO PIP Review Score – Successful Prevention, Early Detection, Treatment, and Recovery for Substance Use Disorders

PIP - Successful Prevention, Early Detection, Treatment, and Recovery for Substance Use Disorders	BHO	CBH	CCBH	MBH	PerformCare	TOTAL PH MMC
1. Project Topic/Rationale	C	C	C	C	C	C
2. Aim	C	C	C	C	C	C
3. Methodology	C	C	C	C	C	C

4. Barrier Analysis	C	C	C	C	C	C
5. Robust Interventions	C	C	C	C	C	C
6. Results	NA	NA	NA	NA	NA	NA
7. Discussion and Validity of Reported Improvement	NA	NA	NA	NA	NA	NA
8. Sustainability	NA	NA	NA	NA	NA	NA

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls is to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. MCOs will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, rather than two semiannual submissions, MCOs will, starting in 2022, submit only one PIP interim report each September, when formal scoring is rendered.

CHC-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each CHC-MCO. For the purposes of the EQR, CHC-MCOs were required to participate in studies selected by DHS OLTL for validation by IPRO in 2018 for 2021 activities. Under the applicable Agreement with DHS in effect during this review period, CHC-MCOs are required to conduct focused studies each year. For all CHC-MCOs, two new PIPs were initiated as part of this requirement in 2019. For all PIPs, CHC-MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

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

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

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

"Strengthening Care Coordination" was selected as a topic following discussions with stakeholders and in collaboration with the EQRO. Each CHC-MCO was required to implement interventions and indicate performance on the topic of strengthening care coordination with assessment and improvement of outcomes of care rendered by the CHC-MCO. Between 2018 and 2020, CHC-MCOs submitted proposals for PIP expansion in sequence with CHC being phased in. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly. Subsequent to each proposal submission, baseline

data in proposals was then updated as supplemental data became available. For this PIP, CHC-MCOs were required to submit rates at the baseline, 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. Each CHC-MCO was required to implement interventions and indicate performance on the topic of transition of care from the nursing facility to the community, entailing assessment and improvement of outcomes of care rendered by the MCO. Between 2018 and 2020, CHC-MCOs submitted proposals for PIP expansion in sequence with CHC being phased in. Eligible populations initially included the Nursing Facility Clinically Eligible (NFCE) participants and expanded accordingly. Subsequent to each proposal submission, baseline data in proposals was then updated as supplemental data became available. For this PIP, CHC-MCOs were required to submit rates at the baseline, 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 CHC-MCOs are required to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

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

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

The first six elements relate to the baseline and demonstrable improvement phases of the project. The seventh element relates to validity of reported improvement, and the eighth element relates to sustainability of this improvement. Each submitted PIP report is evaluated against the eight review elements and associated requirements. For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each applicable element carries a separate weight. Scoring for each applicable element is based on assessment results of full, partial, and non-compliance. Points are awarded for the two phases of the PIP noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance, as described above under the Scoring Matrix subsection: if the element is designated as full compliance (defined as having met or exceeded the element requirements), the designation weight is 100%; if the element is designated as partial compliance (defined as having met essential requirements, but is deficient in some areas), the designation weight is 50%; if the element is designated as not in compliance (defined as having not met the essential requirements of the element), the designation weight is 0%.

Overall Performance Score

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%. For the current RY, the highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for full compliance; refer to **Table 3**). Untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into overall determinations.

Table 3: CHC PIP Review Element Scoring Weights (Scoring Matrix)

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

[1]For the RY of this report, a determination for Element #8 (Sustainability) is not yet applicable based on the phase of CHC PIP implementation.

As also noted in Table 3 (Scoring Matrix), PIPs are also reviewed for the achievement of sustained improvement. For the EQR of CHC-MCO PIPs, sustained improvement elements have a total weight of 20%, for a possible maximum total of 20 points. The MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation by IPRO will occur at the end of the current PIP cycle. In 2021, a determination for Element #8 (Sustainability) is not yet applicable based on the phase of CHC PIP implementation.

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

PIP activities during the year included updating PIP performance indicator (PI) goals, baseline rates, barrier analyses, and development and implementation of interventions as well as additional PIs. For measurement in the PIP, multiple data sources were allowable, including: MCO pharmacies, service coordinator entities,

copayments (i.e., after day 20 for Medicare-covered skilled nursing stays), and traditional long-term care claims. Preliminary measurements were based on participants that were Medicaid-only CHC participants and/or aligned 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 due to the EQRO in July 2021.

Tables 4a and **4b** summarize PIP compliance assessments across CHC-MCOs for Annual PIP Reports (Year 2 Implementation) review findings. The multiple levels of activity and collaboration between DHS, the CHC-MCOs, and IPRO continued and progressed throughout the review year.

Table 4a: CHC-MCO PIP Review Score – Strengthening Care Coordination

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

Note: For the July 2021 PIP Update, PIP submissions for ACP CHC/KF CHC were not submitted in accordance with the submission schedule. Timely submission is required per the CHC Agreement (Exhibit W "External Quality Review"). Timely submission is required for purposes of validation by the EQRO. Consequently, and in discussion with the Department, ACP CHC/KF CHC received overall determinations of partial compliance on PIPs.

Table 4b: CHC-MCO PIP Review Score – Transition of Care from the NF to the Community

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

Note: For the July 2021 PIP Update, PIP submissions for ACP CHC/KF CHC were not submitted in accordance with the submission schedule. Timely submission is required per the CHC Agreement (Exhibit W "External Quality Review"). Timely submission is required for purposes of validation by the EQRO. Consequently, and in discussion with the Department, ACP CHC/KF CHC received overall determinations of partial compliance on PIPs.

- Overall: compliance determinations for elements of Project Topic and Rationale, Methodology, Barrier Analysis, and Robust Interventions were sufficiently met for both PIP topics; however, compliance determinations for elements of Aim, Results, and Discussion were partially met for the Transitions of Care from NF to the Community PIP.
- For each CHC-MCOs' two PIPs, all scores based on the element determinations exceeded ≥ 85%.
- ACP CHC/KF CHC were found to have an issue with timely reporting per the submission schedule.

It is recommended that ACP CHC/KF CHC address the above performance improvement project issue and submit all PIP reports timely per the submission schedule.

Section II: Performance Measures

The BBA requires that performance measures be validated in a manner consistent with the EQR protocol, *Validating Performance Measures*. Audits of MCOs are to be conducted as prescribed in NCQA's *HEDIS MY 2020, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures* and are consistent with the validation method described in the EQRO protocols.

PH-MCO Performance Measures

Each PH-MCO underwent a full HEDIS Compliance Audit in 2021. The PH-MCOs are required by DHS, as part of their Quality Assessment and Performance Improvement (QAPI) programs, to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the *HEDIS MY 2020: Volume 2: Technical Specifications*. All the PH-MCO HEDIS rates are compiled and provided to DHS on an annual basis. **Table 5a** represents the HEDIS performance for all eight PH-MCOs in 2021, as well as the PH MMC mean and the PH MMC weighted average. If the denominator was less than 30 for a particular rate, "N/A" (Not Applicable) appears in the corresponding cells. The arrows indicate improvement (▲) or decline (▼) in the weighted average from the previous year.

Comparisons to fee-for-service Medicaid data are not included in this report as the fee-for-service data and processes were not subject to a HEDIS compliance audit for HEDIS MY 2020 measures.

Table 5a is the full set of HEDIS MY 2020 measures reported to OMAP. The individual MCO 2021 (MY 2020) EQR reports include a subset of these measures.

Table 5a: PH-MCO Results for 2021 (MY 2020) HEDIS Measures

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Effectiveness of Care											
Prevention and Screening											
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)											
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Ages 3-11 years	79.50%	75.22%	83.27%	85.41%	86.78%	75.33%	88.35%	80.00%	81.73%	80.77%	▼
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Ages 12-17 years	74.44%	79.01%	81.88%	85.51%	75.65%	72.17%	84.83%	67.48%	77.62%	76.52%	▼
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Total	77.86%	76.89%	82.73%	85.44%	83.04%	74.27%	87.10%	75.57%	80.36%	79.30%	▼
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition Ages 3-11 years	77.70%	61.30%	77.69%	76.82%	81.50%	74.01%	80.83%	74.22%	75.51%	74.75%	▼

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition Ages 12-17 years	77.44%	65.19%	74.38%	72.46%	77.39%	72.17%	82.07%	62.60%	72.96%	71.56%	▼
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition Total	77.62%	63.02%	76.40%	75.20%	80.12%	73.39%	81.27%	70.11%	74.64%	73.64%	▼
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity Ages 3-11 years	70.86%	57.39%	71.71%	72.96%	67.40%	64.76%	75.19%	69.78%	68.76%	68.07%	▼
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity Ages 12-17 years	74.44%	63.54%	75.00%	71.01%	66.96%	71.30%	84.14%	61.79%	71.02%	69.99%	▼
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity Ages Total	72.02%	60.10%	72.99%	72.24%	67.25%	66.96%	78.35%	66.95%	69.61%	68.78%	▼
Childhood Immunizations Status (CIS)											
Childhood Immunizations Status: DTaP/DT	68.86%	72.75%	74.21%	79.56%	76.89%	81.95%	79.08%	76.64%	76.24%	76.80%	▼
Childhood Immunizations Status: IPV	86.37%	89.05%	92.70%	93.43%	90.75%	91.71%	92.94%	91.73%	91.09%	91.24%	▲
Childhood Immunizations Status: MMR	83.94%	85.40%	90.27%	91.73%	90.02%	90.73%	89.29%	89.29%	88.83%	89.07%	▼
Childhood Immunizations Status: HiB	82.48%	85.16%	89.54%	89.05%	90.27%	92.20%	91.24%	89.05%	88.62%	89.07%	▼
Childhood Immunizations Status: Hepatitis B	86.13%	90.27%	93.19%	92.94%	92.70%	93.41%	94.89%	92.21%	91.97%	92.21%	▲
Childhood Immunizations Status: VZV	83.45%	85.16%	89.29%	91.24%	88.81%	90.49%	89.29%	88.32%	88.26%	88.49%	▼
Childhood Immunizations Status: Pneumococcal Conjugate	72.26%	76.64%	77.37%	82.48%	80.29%	80.24%	80.54%	80.78%	78.83%	79.12%	▼
Childhood Immunizations Status: Hepatitis A	80.05%	80.54%	86.13%	86.62%	88.08%	87.80%	84.43%	85.64%	84.91%	85.27%	▼
Childhood Immunizations Status: Rotavirus	71.05%	69.34%	71.29%	75.67%	72.02%	75.85%	77.62%	74.94%	73.47%	73.65%	▼
Childhood Immunizations Status: Influenza	53.04%	46.23%	49.88%	51.58%	54.74%	60.49%	54.74%	52.31%	52.88%	53.35%	▲
Childhood Immunizations Status: Combination 2	67.15%	70.07%	72.26%	76.89%	74.94%	79.76%	75.91%	75.18%	74.02%	74.65%	▼
Childhood Immunizations Status: Combination 3	64.48%	67.40%	69.59%	74.70%	72.26%	77.32%	73.24%	72.99%	71.50%	72.15%	▼
Childhood Immunizations Status: Combination 4	63.99%	64.72%	68.37%	72.51%	72.02%	76.10%	71.29%	71.29%	70.04%	70.66%	▼
Childhood Immunizations Status: Combination 5	56.20%	60.34%	60.83%	65.45%	61.80%	68.29%	65.21%	63.50%	62.70%	63.31%	▼
Childhood Immunizations Status: Combination 6	42.09%	39.42%	44.04%	45.26%	47.93%	55.37%	47.45%	45.74%	45.91%	46.72%	▲
Childhood Immunizations Status: Combination 7	55.72%	58.15%	60.10%	63.99%	61.56%	67.07%	63.99%	62.29%	61.61%	62.16%	▼
Childhood Immunizations Status: Combination 8	41.85%	38.44%	43.80%	44.53%	47.93%	55.12%	46.96%	45.74%	45.55%	46.39%	▲
Childhood Immunizations Status: Combination 9	37.71%	36.50%	40.88%	40.63%	41.12%	50.24%	42.09%	40.88%	41.26%	42.08%	▲

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Childhood Immunizations Status: Combination 10	37.47%	35.77%	40.88%	39.90%	41.12%	50.00%	41.85%	40.88%	40.98%	41.83%	▲
Immunizations for Adolescents (IMA)											
Immunizations for Adolescents: Meningococcal	82.97%	88.81%	90.02%	88.32%	90.22%	90.02%	88.32%	88.08%	88.35%	88.76%	▼
Immunizations for Adolescents: Tdap/Td	82.97%	91.00%	91.48%	90.27%	90.22%	90.51%	87.59%	89.05%	89.14%	89.61%	▼
Immunizations for Adolescents: HPV	33.58%	38.44%	41.85%	34.31%	48.66%	44.28%	39.66%	40.15%	40.12%	40.90%	▼
Immunizations for Adolescents: Combination #1	81.51%	87.59%	89.29%	87.83%	89.24%	88.81%	86.37%	86.86%	87.19%	87.62%	▼
Immunizations for Adolescents: Combination #2	32.60%	36.98%	40.63%	34.06%	48.17%	42.82%	38.69%	38.69%	39.08%	39.77%	▼
Lead Screening in Children (LSC)											
Lead Screening in Children: Rate	78.68%	79.74%	83.94%	88.32%	80.54%	83.54%	80.78%	87.10%	82.83%	83.22%	▼
Breast Cancer Screening (BCS)											
Breast Cancer Screening: Rate	44.04%	58.52%	52.17%	56.83%	53.93%	52.97%	48.18%	53.32%	52.50%	53.16%	▼
Cervical Cancer Screening (CCS)											
Cervical Cancer Screening: Rate	52.55%	66.50%	61.56%	62.37%	63.33%	65.16%	56.93%	57.37%	60.72%	61.11%	▼
Chlamydia Screening in Women (CHL)											
Chlamydia Screening in Women: Ages 16-20 years	47.88%	47.39%	53.01%	47.33%	69.23%	61.66%	51.16%	49.04%	53.34%	53.67%	▼
Chlamydia Screening in Women: Ages 21-24 years	55.99%	55.49%	60.45%	56.73%	71.51%	68.32%	61.17%	56.54%	60.78%	61.01%	▼
Chlamydia Screening in Women: Total Rate	51.84%	51.03%	56.22%	51.49%	70.27%	64.62%	55.60%	52.42%	56.69%	56.96%	▼
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)											
Non-Recommended Cervical Cancer Screening in Adolescent Females: Rate[1]	0.33%	0.47%	0.25%	1.40%	0.17%	0.08%	0.22%	0.52%	0.43%	0.39%	▲
Respiratory Conditions											
Appropriate Testing for Pharyngitis (CWP)											
Appropriate Testing for Pharyngitis: 3 - 17 years	80.35%	75.28%	80.65%	81.03%	83.31%	84.25%	86.03%	85.81%	82.09%	82.07%	▼
Appropriate Testing for Pharyngitis: 18 - 64 years	59.47%	58.09%	65.36%	62.66%	37.84%	42.46%	65.91%	70.85%	57.83%	59.60%	▼
Appropriate Testing for Pharyngitis: 65+ years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Appropriate Testing for Pharyngitis: Total Rate	72.86%	69.38%	75.61%	75.23%	64.25%	68.70%	78.70%	80.81%	73.19%	74.25%	▼
Appropriate Treatment for Upper Respiratory Infection (URI)											
Appropriate Treatment for Upper Respiratory Infection: 3 months - 17 years	93.58%	93.43%	94.62%	91.19%	96.73%	96.72%	95.09%	92.67%	94.25%	94.21%	▲
Appropriate Treatment for Upper Respiratory Infection: 18 - 64 years	82.89%	83.35%	84.78%	80.29%	83.42%	81.13%	83.23%	78.98%	82.26%	81.97%	▲

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Appropriate Treatment for Upper Respiratory Infection: 65+ years	N/A	83.78%	N/A	N/A	78.18%	74.68%	N/A	N/A	78.88%	77.77%	▲
Appropriate Treatment for Upper Respiratory Infection: Total Rate	90.71%	90.66%	91.92%	88.34%	92.83%	93.02%	91.78%	88.73%	91.00%	90.89%	▲
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)											
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: 3 months - 17 years	72.98%	70.89%	68.28%	63.03%	88.18%	85.43%	76.55%	70.77%	74.51%	73.79%	▲
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: 18 - 64 years	47.92%	43.70%	49.76%	47.74%	47.38%	46.79%	43.09%	45.68%	46.51%	46.26%	▲
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: 65+ years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Total Rate	61.40%	58.11%	59.78%	55.61%	69.90%	71.40%	60.20%	56.95%	61.67%	60.67%	▲
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)											
Use of Spirometry Testing in the Assessment and Diagnosis of COPD: Rate	24.82%	29.29%	25.67%	30.72%	24.90%	23.40%	25.40%	28.70%	26.61%	26.86%	▼
Pharmacotherapy Management of COPD Exacerbation (PCE)											
Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	83.18%	77.06%	77.01%	78.15%	75.71%	71.67%	76.71%	79.59%	77.39%	77.23%	▲
Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	88.30%	88.53%	85.40%	84.46%	91.01%	89.87%	83.90%	86.20%	87.21%	87.29%	▲
Asthma Medication Ratio (AMR)											
Asthma Medication Ratio: 5-11 years	75.87%	78.90%	76.09%	84.03%	77.53%	76.39%	75.11%	79.47%	77.92%	77.58%	▲
Asthma Medication Ratio: 12-18 years	65.48%	73.14%	66.60%	75.54%	71.34%	72.23%	67.09%	70.50%	70.24%	70.96%	▲
Asthma Medication Ratio: 19-50 years	54.43%	56.86%	54.87%	57.29%	61.41%	52.93%	53.59%	60.63%	56.50%	56.70%	▲
Asthma Medication Ratio: 51-64 years	54.92%	56.71%	58.09%	53.30%	61.41%	53.76%	56.83%	63.13%	57.27%	57.59%	▼
Asthma Medication Ratio: Total Rate	62.29%	64.46%	62.15%	65.48%	67.28%	64.59%	62.43%	66.80%	64.43%	64.79%	▲
Cardiovascular Conditions											
Controlling High Blood Pressure (CBP)											
Controlling High Blood Pressure: Total Rate	67.88%	62.53%	71.29%	71.53%	62.77%	51.58%	62.77%	65.45%	64.48%	63.43%	▼
Persistence of Beta Blocker Treatment After a Heart Attack (PBH)											
Persistence of Beta Blocker Treatment After a Heart Attack: Rate	82.93%	91.27%	89.08%	90.18%	82.24%	77.66%	84.68%	89.02%	85.88%	85.91%	▼
Statin Therapy for Patients With Cardiovascular Disease (SPC)											
Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy - 21-75 years (Male)	87.53%	86.76%	83.67%	85.48%	84.11%	85.43%	83.81%	83.46%	85.03%	84.73%	▲

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy - 40-75 years (Female)	82.25%	84.65%	82.70%	84.88%	80.78%	78.50%	82.73%	80.24%	82.09%	81.77%	▲
Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy - Total Rate	85.56%	85.80%	83.23%	85.24%	82.77%	82.86%	83.37%	82.14%	83.87%	83.51%	▲
Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 21-75 years (Male)	74.45%	78.04%	75.79%	77.20%	73.31%	78.00%	73.64%	77.05%	75.94%	76.30%	▲
Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female)	80.62%	75.95%	75.74%	77.85%	73.90%	79.17%	70.88%	76.80%	76.36%	76.36%	▲
Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate	76.66%	77.10%	75.77%	77.47%	73.55%	78.41%	72.52%	76.95%	76.05%	76.32%	▲
Cardiac Rehabilitation (CRE)											
Cardiac Rehabilitation: Initiation - 2 or more sessions within 30 days (Ages 18-64)	4.24%	2.82%	1.54%	2.73%	1.54%	1.24%	1.45%	2.05%	2.20%	2.04%	N/A
Cardiac Rehabilitation: Initiation - 2 or more sessions within 30 days (Ages 65+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cardiac Rehabilitation: Initiation - 2 or more sessions within 30 days (Total)	4.18%	2.78%	1.53%	2.71%	1.52%	1.22%	1.44%	2.05%	2.18%	2.02%	N/A
Cardiac Rehabilitation: Engagement 1 - 12 or more sessions within 90 days (Ages 18-64)	6.71%	3.05%	2.20%	2.73%	2.41%	2.02%	2.90%	2.25%	3.03%	2.73%	N/A
Cardiac Rehabilitation: Engagement 1 - 12 or more sessions within 90 days (Ages 65+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cardiac Rehabilitation: Engagement 1 - 12 or more sessions within 90 days (Total)	6.62%	3.01%	2.40%	2.71%	2.38%	1.98%	2.87%	2.24%	3.03%	2.73%	N/A
Cardiac Rehabilitation: Engagement 2 - 24 or more sessions within 180 days (Ages 18-64)	6.71%	1.88%	2.20%	2.46%	2.41%	1.86%	2.17%	1.76%	2.68%	2.36%	N/A
Cardiac Rehabilitation: Engagement 2 - 24 or more sessions within 180 days (Ages 65+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cardiac Rehabilitation: Engagement 2 - 24 or more sessions within 180 days (Total)	6.62%	1.85%	2.18%	2.44%	2.38%	1.83%	2.15%	1.75%	2.65%	2.33%	N/A
Cardiac Rehabilitation: Achievement - 36 or more sessions within 180 days (Ages 18-64)	6.36%	0.47%	0.66%	0.82%	0.44%	0.78%	0.24%	0.98%	1.34%	1.08%	N/A
Cardiac Rehabilitation: Achievement - 36 or more sessions within 180 days (Ages 18-64)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cardiac Rehabilitation: Achievement - 36 or more sessions within 180 days (Total)	6.27%	0.46%	0.65%	0.81%	0.43%	0.76%	0.24%	0.97%	1.32%	1.07%	N/A
Diabetes											
Comprehensive Diabetes Care (CDC)											
Comprehensive Diabetes Care: HbA1c Testing	80.54%	88.32%	85.16%	86.62%	81.75%	78.35%	82.24%	85.64%	83.58%	83.66%	▼

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)[2]	36.98%	38.44%	36.01%	33.58%	43.31%	41.85%	37.47%	36.98%	38.08%	38.40%	▼
Comprehensive Diabetes Care: HbA1c Control (< 8.0%)	52.80%	52.07%	52.80%	52.07%	48.42%	49.15%	51.34%	52.31%	51.37%	51.24%	▼
Comprehensive Diabetes Care: Eye Exam	42.82%	58.15%	53.53%	63.75%	45.50%	45.26%	53.04%	60.34%	52.80%	53.34%	▼
Comprehensive Diabetes Care: Blood Pressure Controlled (< 140/90 mm Hg)	59.12%	68.37%	68.61%	75.43%	61.80%	59.85%	68.61%	67.64%	66.18%	66.04%	▼
Statin Therapy for Patients With Diabetes (SPD)											
Statin Therapy for Patients With Diabetes: Received Statin Therapy	66.75%	69.56%	69.53%	68.39%	72.00%	70.29%	68.28%	69.43%	69.28%	69.62%	▲
Statin Therapy for Patients With Diabetes: Statin Adherence 80%	74.28%	75.89%	73.83%	75.12%	68.83%	73.02%	69.48%	77.66%	73.51%	73.79%	▲
Kidney Health Evaluation for Patients with Diabetes (KED)											
Kidney Health Evaluation for Patients with Diabetes: Ages 18 - 64 years	36.55%	39.32%	38.59%	40.48%	42.57%	37.71%	36.20%	37.01%	38.55%	38.55%	N/A
Kidney Health Evaluation for Patients with Diabetes: Ages 65 - 74 years	36.45%	42.23%	46.58%	37.63%	53.35%	44.75%	46.31%	44.65%	43.99%	45.42%	N/A
Kidney Health Evaluation for Patients with Diabetes: Ages 75 - 85 years	37.14%	38.95%	40.30%	N/A	48.04%	38.15%	28.30%	55.00%	40.84%	40.53%	N/A
Kidney Health Evaluation for Patients with Diabetes: Total Rate	36.55%	39.37%	38.71%	40.49%	42.93%	37.94%	36.35%	37.12%	38.68%	38.70%	N/A
Musculoskeletal											
Use of Imaging Studies for Low Back Pain (LBP)											
Use of Imaging Studies for Low Back Pain: Rate	74.23%	74.63%	74.21%	74.30%	82.56%	81.44%	77.28%	77.71%	77.05%	77.20%	▲
Behavioral Health											
Follow-up Care for Children Prescribed ADHD Medication (ADD)											
Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase	30.77%	48.52%	52.07%	47.41%	61.82%	36.74%	43.11%	53.78%	46.78%	47.55%	▲
Follow-up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	29.25%	54.35%	60.96%	46.68%	65.65%	44.86%	50.77%	59.58%	51.51%	52.84%	▲
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)											
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications: Rate	85.12%	86.17%	87.21%	90.29%	78.76%	83.39%	83.26%	87.84%	85.26%	85.62%	▼
Diabetes Monitoring for People With Diabetes And Schizophrenia (SMD)											
Diabetes Monitoring for People With Diabetes And Schizophrenia: Rate	67.52%	71.37%	70.14%	79.66%	70.23%	67.25%	61.17%	73.46%	70.10%	69.74%	▼

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia (SMC)											
Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia: Rate	N/A	N/A	72.22%	N/A	76.92%	66.67%	N/A	75.93%	72.94%	72.99%	▼
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)											
Adherence to Antipsychotic Medications for Individuals With Schizophrenia: Rate	56.65%	68.31%	69.72%	61.67%	61.20%	68.44%	56.03%	68.85%	63.86%	65.13%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)											
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing Ages 1 - 11 years	65.63%	63.34%	72.61%	70.93%	36.45%	58.06%	64.71%	66.55%	62.29%	65.36%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing Ages 12 - 17 years	75.87%	71.67%	73.54%	76.96%	58.21%	66.19%	63.86%	75.41%	70.21%	71.85%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing Total Rate	72.48%	68.83%	73.27%	74.79%	52.20%	63.93%	64.10%	72.50%	67.76%	69.80%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing Ages 1 - 11 years	59.77%	59.49%	68.88%	67.05%	49.53%	57.32%	62.75%	60.00%	60.60%	61.72%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing Ages 12 - 17 years	61.97%	60.58%	61.28%	61.30%	62.50%	59.12%	51.87%	61.65%	60.03%	60.25%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing Total Rate	61.24%	60.21%	63.48%	63.37%	58.91%	58.62%	54.96%	61.11%	60.24%	60.72%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Ages 1 - 11 years	56.25%	56.27%	67.01%	64.53%	34.58%	52.85%	58.43%	57.47%	55.92%	58.36%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Ages 12 - 17 years	60.04%	58.08%	60.19%	60.65%	50.00%	55.78%	50.31%	60.58%	56.95%	58.17%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Total Rate	58.79%	57.46%	62.16%	62.05%	45.74%	54.97%	52.62%	59.56%	56.67%	58.23%	▼
Pharmacotherapy for Opioid Use Disorder (POD)											
Pharmacotherapy for Opioid Use Disorder: Ages 16 - 64 years	23.32%	29.88%	27.97%	34.54%	20.18%	24.50%	24.99%	29.85%	26.90%	27.19%	▲
Pharmacotherapy for Opioid Use Disorder: Ages 65+ year	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacotherapy for Opioid Use Disorder: Total Rate	23.32%	29.91%	28.05%	34.54%	20.11%	24.46%	24.94%	29.85%	26.90%	27.18%	▲
Antidepressant Medication Management (AMM)											
Antidepressant Medication Management: Effective Acute Phase Treatment	53.93%	57.79%	55.08%	61.32%	50.51%	53.23%	54.62%	61.56%	56.01%	56.77%	N/A

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Antidepressant Medication Management: Effective Continuation Phase Treatment	40.29%	43.46%	39.07%	42.62%	35.51%	39.59%	38.57%	44.84%	40.49%	41.16%	N/A
Overuse/Appropriateness											
Risk of Continued Opioid Use (COU)[3]											
Risk of Continued Opioid Use: 18-64 years - ≥ 15 Days covered	5.20%	3.86%	4.44%	3.66%	5.29%	6.50%	3.20%	6.35%	4.81%	5.06%	▼
Risk of Continued Opioid Use: 65+ years - ≥ 15 Days covered	N/A	4.17%	7.50%	N/A	11.63%	3.85%	0.00%	15.15%	7.05%	6.38%	▼
Risk of Continued Opioid Use: Total - ≥ 15 Days covered	5.20%	3.86%	4.45%	3.65%	5.33%	6.48%	3.19%	6.36%	4.82%	5.07%	▼
Risk of Continued Opioid Use: 18-64 years - ≥ 31 Days covered	1.60%	2.88%	2.63%	1.93%	3.21%	4.98%	2.31%	3.72%	2.91%	3.15%	▼
Risk of Continued Opioid Use: 65+ years - ≥ 31 Days covered	N/A	2.08%	2.50%	N/A	6.98%	2.56%	0.00%	9.09%	3.87%	3.54%	▼
Risk of Continued Opioid Use: Total - ≥ 31 Days covered	1.59%	2.88%	2.63%	1.92%	3.23%	4.97%	2.30%	3.73%	2.91%	3.15%	▼
Use of Opioids at High Dosage (HDO)[4]											
Use of Opioids at High Dosage: Rate	8.35%	8.29%	6.92%	7.38%	6.15%	17.92%	9.27%	6.08%	8.80%	8.57%	▲
Use of Opioids from Multiple Providers (UOP)[5]											
Use of Opioids from Multiple Providers: Rate receiving prescription opioids (4 or more prescribers)	18.62%	9.39%	12.30%	13.67%	10.15%	8.28%	16.27%	16.99%	13.21%	13.64%	▲
Use of Opioids from Multiple Providers: Rate receiving prescription opioids (4 or more pharmacies)	3.93%	0.45%	1.10%	0.41%	1.97%	2.37%	1.44%	1.13%	1.60%	1.42%	▲
Use of Opioids from Multiple Providers: Rate receiving prescription opioids (4 or more prescribers & pharmacies)	2.37%	0.23%	0.47%	0.33%	0.93%	0.76%	0.72%	0.52%	0.79%	0.65%	▲
Access/Availability of Care											
Adults' Access to Preventive/Ambulatory Health Services (AAP)											
Adults' Access to Preventive/Ambulatory Health Services: Ages 20-44 years	65.57%	80.30%	78.99%	81.44%	68.68%	71.30%	70.15%	81.73%	74.77%	75.15%	▼
Adults' Access to Preventive/Ambulatory Health Services: Ages 45-64 years	72.79%	86.95%	85.73%	87.02%	79.82%	80.71%	77.51%	87.07%	82.20%	82.88%	▼
Adults' Access to Preventive/Ambulatory Health Services: Ages 65+ years	59.48%	77.44%	76.22%	79.72%	73.63%	72.86%	70.74%	77.19%	73.41%	73.30%	▼
Adults' Access to Preventive/Ambulatory Health Services: Total Rate	67.62%	82.43%	81.10%	83.23%	72.29%	74.30%	72.40%	83.56%	77.12%	77.61%	▼
Annual Dental Visits (ADV)											
Annual Dental Visits: Ages 2 - 3 years	30.55%	50.85%	43.33%	29.80%	42.96%	49.55%	40.32%	43.76%	41.39%	43.09%	▼

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Annual Dental Visits: Ages 4 - 6 years	47.85%	63.36%	59.10%	52.28%	55.61%	63.21%	57.94%	62.42%	57.72%	59.06%	▼
Annual Dental Visits: Ages 7 - 10 years	52.54%	65.60%	61.04%	55.14%	55.57%	62.46%	61.35%	64.94%	59.83%	60.79%	▼
Annual Dental Visits: Ages 11 - 14 years	47.83%	62.90%	60.88%	48.68%	52.30%	61.22%	59.66%	61.97%	56.93%	58.30%	▼
Annual Dental Visits: Ages 15 - 18 years	40.62%	56.97%	55.83%	41.68%	41.27%	54.45%	53.00%	55.79%	49.95%	51.40%	▼
Annual Dental Visits: Ages 19 - 20 years	24.83%	48.05%	39.59%	31.05%	27.60%	44.18%	36.90%	39.53%	36.47%	37.80%	▼
Annual Dental Visits: Total Rate	43.61%	59.93%	55.93%	45.74%	48.39%	57.84%	54.16%	57.54%	52.89%	54.23%	▼
Prenatal and Postpartum Care (PPC)											
Prenatal and Postpartum Care: Timeliness of Prenatal Care	86.86%	91.48%	87.83%	88.32%	90.27%	87.10%	89.29%	89.78%	88.87%	88.93%	▼
Prenatal and Postpartum Care: Postpartum Care	78.10%	81.27%	75.43%	77.37%	79.81%	79.81%	79.08%	72.99%	77.98%	77.80%	▼
Utilization and Risk Adjusted Utilization											
Utilization											
Well-Child Visits in the First 30 Months of Life (W30)											
Well-Child Visits in the First 30 Months of Life: Well-Child Visits in the First 15 Months (6 or more visits)	55.96%	69.15%	66.54%	66.41%	62.27%	59.21%	63.20%	73.92%	64.58%	65.19%	▼
Well-Child Visits in the First 30 Months of Life: Well-Child Visits for Age 15 Months - 30 Months (2 or more visits)	73.44%	76.08%	74.43%	77.70%	69.67%	72.69%	72.30%	79.08%	74.42%	74.61%	N/A
Child and Adolescent Well-Care Visits (WCV)											
Child and Adolescent Well-Care Visits: 3 - 11 years	56.19%	61.05%	62.52%	62.27%	55.36%	58.77%	58.96%	65.33%	60.06%	60.45%	N/A
Child and Adolescent Well-Care Visits: 12 - 17 years	50.38%	55.21%	58.71%	58.20%	47.65%	51.44%	52.83%	60.34%	54.34%	54.68%	N/A
Child and Adolescent Well-Care Visits: 18 - 21 years	28.37%	33.62%	39.00%	36.39%	32.04%	34.04%	32.75%	39.69%	34.49%	35.04%	N/A
Child and Adolescent Well-Care Visits: Total Rate	49.97%	55.09%	57.57%	56.71%	49.42%	52.51%	52.42%	59.74%	54.18%	54.60%	N/A
Frequency of Selected Procedures (FSP)											
Frequency of Selected Procedures: Bariatric Weight Loss Surgery F Ages 0-19 Procs/1,000 MM	0.01	0.01	0.00	0.01	0.01	0.00	0.01	0.00	0.01		
Frequency of Selected Procedures: Bariatric Weight Loss Surgery F Ages 20-44 Procs/1,000 MM	0.23	0.40	0.23	0.27	0.27	0.19	0.36	0.25	0.28		
Frequency of Selected Procedures: Bariatric Weight Loss Surgery F Ages 45-64 Procs/1,000 MM	0.22	0.41	0.20	0.19	0.15	0.17	0.27	0.20	0.23		
Frequency of Selected Procedures: Bariatric Weight Loss Surgery M Ages 0-19 Procs/1,000 MM	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Frequency of Selected Procedures: Bariatric Weight Loss Surgery M Ages 20-44 Procs/1,000 MM	0.03	0.07	0.02	0.05	0.03	0.03	0.02	0.02	0.03		

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average
Frequency of Selected Procedures: Bariatric Weight Loss Surgery M Ages 45-64 Procs/1,000 MM	0.03	0.09	0.08	0.04	0.01	0.04	0.04	0.04	0.05	
Frequency of Selected Procedures: Tonsillectomy MF Ages 0-9 Procs/1,000 MM	0.37	0.48	0.40	0.49	0.32	0.27	0.30	0.44	0.38	
Frequency of Selected Procedures: Tonsillectomy MF Ages 10-19 Procs/1,000 MM	0.18	0.18	0.18	0.18	0.12	0.13	0.12	0.23	0.17	
Frequency of Selected Procedures: Hysterectomy Abdominal F Ages 15-44 Procs/1,000 MM	0.06	0.07	0.09	0.08	0.05	0.05	0.03	0.06	0.06	
Frequency of Selected Procedures: Hysterectomy Abdominal F Ages 45-64 Procs/1,000 MM	0.13	0.15	0.17	0.14	0.14	0.17	0.11	0.14	0.14	
Frequency of Selected Procedures: Hysterectomy Vaginal F Ages 15-44 Procs/1,000 MM	0.05	0.08	0.07	0.08	0.04	0.03	0.06	0.11	0.07	
Frequency of Selected Procedures: Hysterectomy Vaginal F Ages 45-64 Procs/1,000 MM	0.10	0.09	0.14	0.06	0.13	0.05	0.06	0.10	0.09	
Frequency of Selected Procedures: Cholecystectomy, Open M Ages 30-64 Procs/1,000 MM	0.02	0.02	0.02	0.02	0.03	0.03	0.02	0.03	0.02	
Frequency of Selected Procedures: Cholecystectomy, Open F Ages 15-44 Procs/1,000 MM	0.01	0.01	0.01	0.01	0.01	0.00	0.01	0.01	0.01	
Frequency of Selected Procedures: Cholecystectomy Open F Ages 45-64 Procs/1,000 MM	0.02	0.02	0.02	0.02	0.02	0.03	0.04	0.02	0.02	
Frequency of Selected Procedures: Cholecystectomy Closed M Ages 30-64 Procs/1,000 MM	0.17	0.23	0.24	0.29	0.09	0.11	0.21	0.30	0.21	
Frequency of Selected Procedures: Cholecystectomy Closed F Ages 15-44 Procs/1,000 MM	0.47	0.62	0.53	0.60	0.29	0.26	0.44	0.62	0.48	
Frequency of Selected Procedures: Cholecystectomy Closed F Ages 45-64 Procs/1,000 MM	0.39	0.53	0.50	0.48	0.28	0.28	0.46	0.58	0.44	
Frequency of Selected Procedures: Back Surgery M Ages 20-44 Procs/1,000 MM	0.14	0.17	0.14	0.23	0.07	0.10	0.12	0.22	0.15	
Frequency of Selected Procedures: Back Surgery F Ages 20-44 Procs/1,000 MM	0.12	0.16	0.15	0.17	0.05	0.07	0.12	0.18	0.13	
Frequency of Selected Procedures: Back Surgery M Ages 45-64 Procs/1,000 MM	0.44	0.55	0.51	0.64	0.26	0.32	0.42	0.66	0.48	
Frequency of Selected Procedures: Back Surgery F Ages 45-64 Procs/1,000 MM	0.42	0.44	0.52	0.59	0.17	0.26	0.46	0.61	0.43	
Frequency of Selected Procedures: Mastectomy F Ages 15-44 Procs/1,000 MM	0.03	0.07	0.05	0.06	0.04	0.10	0.05	0.06	0.06	
Frequency of Selected Procedures: Mastectomy F Ages 45-64 Procs/1,000 MM	0.17	0.11	0.21	0.14	0.08	0.17	0.14	0.14	0.15	

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Frequency of Selected Procedures: Lumpectomy F Ages 15-44 Procs/1,000 MM	0.07	0.11	0.11	0.10	0.08	0.10	0.10	0.09	0.10		
Frequency of Selected Procedures: Lumpectomy F Ages 45-64 Procs/1,000 MM	0.24	0.34	0.22	0.37	0.23	0.32	0.28	0.28	0.29		
Ambulatory Care: Total (AMBA)											
Ambulatory Care: Total: Outpatient Visits/1,000 MM	246.30	354.74	319.31	342.68	248.22	253.68	273.73	391.73	303.80	307.80	▼
Ambulatory Care: Total: Emergency Department Visits/1,000 MM	47.13	55.21	55.38	43.61	47.58	44.05	47.22	49.79	48.75	48.76	▼
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)											
Inpatient Utilization - General Hospital/Acute Care: Total Discharges/1,000 MM	4.82	5.66	6.49	5.79	6.10	6.78	6.45	6.34	6.05		
Inpatient Utilization - General Hospital/Acute Care: Medicine Discharges/1,000 MM	1.98	2.47	2.96	2.71	3.01	3.48	3.26	2.61	2.81		
Inpatient Utilization - General Hospital/Acute Care: Surgery Discharges/1,000 MM	1.16	1.23	1.60	1.27	1.20	1.43	1.47	1.82	1.40		
Inpatient Utilization - General Hospital/Acute Care: Maternity Discharges/1,000 MM	2.26	2.73	2.68	2.43	2.52	2.60	2.29	2.57	2.51		
Antibiotic Utilization: Total (ABXA)											
Antibiotic Utilization: Total: Total # of Antibiotic Prescriptions M&F	130,539	180,739	167,235	151,291	121,062	221,500	122,721	334,651	178,717		
Antibiotic Utilization: Total: Average # of Antibiotic Prescriptions PMPY M&F	0.67	0.68	0.67	0.79	0.51	0.55	0.58	0.85	0.66		
Antibiotic Utilization: Total: Total Days Supplied for all Antibiotic Prescriptions M&F	1,073,627	1,723,941	1,597,965	1,517,359	1,060,640	2,037,650	1,170,901	3,036,933	1,652,377		
Antibiotic Utilization: Total: Average # Days Supplied per Antibiotic Prescription M&F	8.22	9.54	9.56	10.03	8.76	9.20	9.54	9.07	9.24		
Antibiotic Utilization: Total: Total # of Prescriptions for Antibiotics of Concern M&F	49,388	63,669	57,497	60,251	38,787	72,871	41,789	127,839	64,011		
Antibiotic Utilization: Total: Average # of Prescriptions for Antibiotics of Concern M&F	0.25	0.24	0.23	0.31	0.16	0.18	0.20	0.33	0.24		
Antibiotic Utilization: Total: Percent Antibiotics of Concern of all Antibiotic Prescriptions	37.83%	35.23%	34.38%	39.82%	32.04%	32.90%	34.05%	38.20%	35.56%		
Risk Adjusted Utilization											
Plan All-Cause Readmissions (PCR)											
Plan All-Cause Readmissions: Count of Index Hospital Stays (IHS) - Total Stays (Ages 18-44)	1,667	2,338	3,316	2,369	2,786	4,847	2,637	6,747	3,338		

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average
Plan All-Cause Readmissions: Count of Index Hospital Stays (IHS) - Total Stays (Ages 45-54)	858	1,467	1,864	1,345	1,569	2,426	1,297	4,058	1,861	
Plan All-Cause Readmissions: Count of Index Hospital Stays (IHS) - Total Stays (Ages 55-64)	1,049	1,635	2,312	1,479	1,920	3,058	1,565	4,922	2,243	
Plan All-Cause Readmissions: Count of Index Hospital Stays (IHS) - Total Stays (Ages Total)	3,574	5,440	7,492	5,193	6,275	10,331	5,499	15,727	7,441	
Plan All-Cause Readmissions: Count of Observed 30-Day Readmissions-Total Stays (Ages 18-44)	122	226	326	141	281	504	255	432	286	
Plan All-Cause Readmissions: Count of Observed 30-Day Readmissions-Total Stays (Ages 45-54)	96	171	199	113	183	296	150	325	192	
Plan All-Cause Readmissions: Count of Observed 30-Day Readmissions-Total Stays (Ages 55-64)	151	199	270	141	209	398	194	407	246	
Plan All-Cause Readmissions: Count of Observed 30-Day Readmissions-Total Stays (Ages Total)	369	596	795	395	673	1,198	599	1,164	724	
Plan All-Cause Readmissions: Count of Expected 30-Day Readmissions-Total Stays (Ages 18-44)	142.88	198.69	274.62	198.47	230.08	401.35	221.17	542.03	276.16	
Plan All-Cause Readmissions: Count of Expected 30-Day Readmissions-Total Stays (Ages 45-54)	92.31	152.29	189.83	134.83	160.61	247.05	129.83	390.57	187.17	
Plan All-Cause Readmissions: Count of Expected 30-Day Readmissions-Total Stays (Ages 55-64)	126.13	195.18	273.29	171.03	224.12	360.58	179.89	547.17	259.67	
Plan All-Cause Readmissions: Count of Expected 30-Day Readmissions-Total Stays (Ages Total)	361.32	546.15	737.75	504.34	614.82	1,008.97	530.89	1,479.78	723.00	
Plan All-Cause Readmissions: Observed Readmission Rate - Total Stays (Ages 18-44)	7.32%	9.67%	9.83%	5.95%	10.09%	10.40%	9.67%	6.40%	8.67%	
Plan All-Cause Readmissions: Observed Readmission Rate - Total Stays (Ages 45-54)	11.19%	11.66%	10.68%	8.40%	11.66%	12.20%	11.57%	8.01%	10.67%	
Plan All-Cause Readmissions: Observed Readmission Rate - Total Stays (Ages 55-64)	14.39%	12.17%	11.68%	9.53%	10.89%	13.02%	12.40%	8.27%	11.54%	
Plan All-Cause Readmissions: Observed Readmission Rate - Total Stays (Ages Total)	10.32%	10.96%	10.61%	7.61%	10.73%	11.60%	10.89%	7.40%	10.02%	
Plan All-Cause Readmissions: Expected Readmission Rate - Total Stays (Ages 18-44)	8.57%	8.50%	8.28%	8.38%	8.26%	8.28%	8.39%	8.03%	8.34%	
Plan All-Cause Readmissions: Expected Readmission Rate - Total Stays (Ages 45-54)	10.76%	10.38%	10.18%	10.02%	10.24%	10.18%	10.01%	9.62%	10.17%	
Plan All-Cause Readmissions: Expected Readmission Rate - Total Stays (Ages 55-64)	12.02%	11.94%	11.82%	11.56%	11.67%	11.79%	11.49%	11.12%	11.68%	
Plan All-Cause Readmissions: Expected Readmission Rate - Total Stays (Ages Total)	10.11%	10.04%	9.85%	9.71%	9.80%	9.77%	9.65%	9.41%	9.79%	

PH MCO HEDIS Measure	ABH	ACP	GH	GEI	HPP	KF	UHC	UPMC	PA PH MEAN	Weighted Average	
Plan All-Cause Readmissions: Observed to Expected Readmission Ratio - Total Stays (Ages Total)	1.02	1.09	1.08	0.78	1.09	1.19	1.13	0.79	1.02		
Measures Reported Using Electronic Clinical Data Systems											
Prenatal Immunization Status (PRS-E)											
Prenatal Immunization Status: Influenza	33.97%	40.56%	40.04%	37.82%	41.97%	43.69%	41.45%	36.65%	39.52%	39.73%	N/A
Prenatal Immunization Status: Tdap	63.94%	71.46%	70.67%	70.26%	69.09%	66.11%	66.53%	66.45%	68.06%	67.98%	N/A
Prenatal Immunization Status: Combination	28.77%	35.42%	35.50%	32.99%	36.89%	36.82%	35.40%	31.17%	34.12%	34.25%	N/A

[1] For the Non-Recommended Cervical Cancer Screening in Adolescent Females measure, lower rate indicates better performance.
[2] For HbA1c Poor Control, lower rates indicate better performance.
[3] For the Risk of Continued Opioid Use measure, lower rates indicate better performance.
[4] For the Use of Opioids at High Dosage measure, lower rates indicate better performance.
[5] For the Use of Opioids From Multiple Providers measure, lower rates indicate better performance.
Note: Gray shading indicates IPRO does not provide or calculate these rates.

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

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

Results for PAPMs are presented for each PH-MCO in **Table 5b**, along with the PH MMC average and PH MMC weighted average, which takes into account the proportional relevance of each MCO.

Table 5b: PH-MCO Results for 2021 (MY 2020) PAPMs

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Annual Dental Visits for Members with Developmental Disabilities (ADD – Age 2-20 years)										
Annual Dental Visits for Members with Developmental Disabilities: Rate	46.69%	60.94%	46.52%	56.57%	48.80%	58.63%	50.50%	59.66%	53.54%	55.49%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit (PSS)										
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking	66.75%	55.26%	86.05%	57.51%	84.52%	77.55%	89.14%	96.28%	76.63%	75.90%

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA Indicator)	66.50%	53.91%	86.05%	56.44%	84.28%	76.87%	85.93%	95.48%	75.68%	74.95%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure	32.04%	31.32%	54.85%	17.60%	70.52%	48.07%	60.74%	71.54%	48.33%	47.38%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking	85.71%	79.57%	82.27%	62.04%	78.38%	83.81%	88.28%	81.40%	80.18%	80.21%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke	78.95%	70.59%	82.47%	67.65%	92.68%	70.59%	82.43%	81.93%	78.41%	80.00%
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation	20.73%	22.22%	14.39%	30.95%	25.49%	24.24%	32.00%	20.93%	23.87%	23.63%
Perinatal Depression Screening (PDS)										
Perinatal Depression Screening: Prenatal Screen for Depression	52.43%	46.09%	71.39%	45.92%	84.03%	61.22%	85.68%	90.46%	67.15%	66.18%
Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA Indicator)	41.99%	39.82%	69.27%	39.27%	78.62%	56.01%	76.79%	27.25%	53.63%	53.59%
Perinatal Depression Screening: Prenatal Screening Positive for Depression	19.91%	21.36%	27.15%	32.24%	7.60%	16.67%	28.53%	22.34%	21.98%	21.64%
Perinatal Depression Screening: Prenatal Counseling for Depression	62.79%	75.00%	68.29%	85.51%	92.31%	68.18%	81.82%	86.59%	77.56%	77.91%
Perinatal Depression Screening: Postpartum Screening for Depression	67.42%	50.14%	74.43%	60.63%	77.78%	62.92%	92.28%	93.85%	72.43%	71.44%
Perinatal Depression Screening: Postpartum Screening Positive for Depression	15.31%	19.89%	22.52%	18.96%	7.34%	11.16%	18.73%	25.00%	17.36%	17.36%
Perinatal Depression Screening: Postpartum Counseling for Depression	71.88%	77.78%	83.05%	87.50%	94.74%	52.00%	92.86%	100.00%	82.47%	85.06%

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (include the BH data) (ADD-CH)										
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication: Initiation Phase	30.77%	48.52%	47.41%	52.07%	61.82%	36.74%	43.11%	53.78%	46.78%	47.55%
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication: Continuation Phase	29.25%	54.35%	46.68%	60.96%	65.65%	44.86%	50.77%	59.58%	51.51%	52.84%
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (BH Enhanced): Initiation Phase	31.60%	48.48%	47.84%	50.67%	62.85%	37.71%	43.24%	52.24%	46.83%	47.39%
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (BH Enhanced): Continuation Phase	30.33%	53.99%	48.16%	59.75%	66.18%	44.19%	49.71%	58.20%	51.32%	52.31%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)										
SAA Rate: MCO Defined	56.65%	68.31%	61.67%	69.72%	61.20%	68.44%	56.03%	68.85%	63.86%	65.13%
SAA Rate: BH ED Enhanced	58.25%	70.04%	65.14%	73.46%	59.69%	69.44%	67.00%	73.16%	67.02%	68.12%
Asthma in Children and Younger Adults Admission Rate (AAR) (PQI 15)										
Asthma in Children and Younger Adults Admission Rate (Age 2-17 years) per 100,000 member months[1]	2.90	3.87	2.09	6.38	12.43	12.93	6.12	4.93	5.74	7.11
Asthma in Children and Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months[1]	2.36	5.09	4.38	4.85	8.61	8.08	7.73	3.80	4.99	5.71
Asthma in Children and Younger Adults Admission Rate (Age 2-39 years) per 100,000 member months[1]	2.61	4.42	3.14	5.71	10.56	10.84	6.91	4.39	5.40	6.46
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (COPD) (PQI 05)										
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 40-64 years) per 100,000 member months[1]	23.85	32.59	33.90	48.35	42.30	58.98	48.81	36.33	36.12	41.76
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 65+ years) per 100,000 member months[1]	29.06	13.57	32.87	57.13	88.60	33.52	53.23	58.64	40.73	46.72

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 40+ years) per 100,000 member months[1]	23.96	32.18	33.89	48.50	43.72	58.14	48.92	36.57	36.21	41.86
Diabetes Short-Term Complications Admission Rate (DAR) (PQI 01)										
Diabetes Short-Term Complications Admission Rate (18-64 Years) per 100,000 member months[1]	10.39	18.34	24.23	25.49	14.36	24.04	18.89	17.97	17.08	19.39
Diabetes Short-Term Complications Admission Rate (65+ Years) per 100,000 member months[1]	9.69	6.79	0.00	0.00	9.84	6.09	7.60	0.00	4.45	5.84
Diabetes Short-Term Complications Admission Rate (Age 18+ Years) per 100,000 member months[1]	10.39	18.24	24.11	25.32	14.30	23.80	18.79	17.89	16.98	19.27
Heart Failure Admission Rate (HF) (PQI 08)										
Heart Failure Admission Rate (18-64 Years) per 100,000 member months[1]	12.92	16.47	15.93	23.14	24.84	23.84	24.95	16.87	17.66	20.05
Heart Failure Admission Rate (65+ Years) per 100,000 member months[1]	19.37	95.00	82.17	199.94	49.22	24.38	144.48	75.39	76.66	73.41
Heart Failure Admission Rate (Age 18+ Years) per 100,000 member months[1]	12.96	17.14	16.26	24.31	25.13	23.84	26.03	17.14	18.09	20.50
Developmental Screening in the First Three Years of Life (CHIPRA Measure DEV-CH)										
Developmental Screening in the First Three Years of Life: Total	61.44%	59.47%	63.88%	60.36%	49.56%	58.02%	60.78%	63.56%	59.63%	59.65%
Developmental Screening in the First Three Years of Life: 1 year	59.17%	52.87%	60.98%	54.18%	42.07%	54.45%	60.19%	60.44%	55.55%	55.50%
Developmental Screening in the First Three Years of Life: 2 years	62.14%	61.53%	63.83%	63.10%	53.10%	57.67%	60.21%	64.25%	60.73%	60.68%
Developmental Screening in the First Three Years of Life: 3 years	63.12%	64.47%	67.03%	63.78%	53.31%	61.71%	61.92%	66.12%	62.68%	62.76%
Sealant Receipt on Permanent First Molars (SFM-CH)										
Sealant Receipt on Permanent First Molars: ≥ 1 Molar	19.40%	6.44%	46.24%	55.83%	63.95%	5.27%	36.77%	35.63%	33.69%	31.26%
Sealant Receipt on Permanent First Molars: All 4 Molars	12.04%	3.84%	35.13%	40.63%	45.25%	2.69%	22.79%	20.42%	22.85%	20.90%

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Contraceptive Care for all Women (CCW)										
Contraceptive Care for all Women: Provision of most or moderately effective contraception (Ages 15-20)	31.06%	32.45%	35.16%	32.73%	24.66%	26.31%	30.01%	37.99%	31.29%	31.26%
Contraceptive Care for all Women: Provision of LARC contraception (Ages 15-20)	2.72%	3.94%	2.85%	4.06%	2.77%	2.42%	3.46%	4.15%	3.30%	3.32%
Contraceptive Care for all Women: Provision of most or moderately effective contraception (Ages 21-44)	26.19%	28.75%	28.03%	27.46%	26.71%	28.14%	26.22%	28.15%	27.46%	27.62%
Contraceptive Care for all Women: Provision of LARC (Ages 21-44)	3.88%	5.14%	3.80%	4.64%	3.98%	4.05%	4.23%	4.77%	4.31%	4.36%
Contraceptive Care for all Women: Provision of most or moderately effective contraception (Ages 15-44)	27.27%	29.67%	29.82%	28.86%	26.23%	27.65%	27.24%	30.33%	28.38%	28.52%
Contraceptive Care for all Women: Provision of LARC (Ages 15-44)	3.62%	4.84%	3.56%	4.49%	3.71%	3.61%	4.02%	4.63%	4.06%	4.10%
Contraceptive Care for Postpartum Women (CCP)										
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15-20)	10.38%	18.93%	12.45%	11.55%	25.66%	22.89%	11.65%	11.83%	15.67%	16.22%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15-20)	41.52%	55.82%	42.49%	46.40%	48.92%	49.09%	39.30%	47.49%	46.38%	47.23%
Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15-20)	4.15%	12.43%	4.03%	7.20%	17.27%	12.27%	7.05%	5.38%	8.72%	9.20%
Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15-20)	9.69%	20.91%	9.52%	15.15%	23.50%	19.73%	14.63%	15.05%	16.02%	16.79%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 21-44)	14.33%	19.40%	16.72%	18.30%	24.20%	23.16%	18.73%	16.78%	18.95%	19.30%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21-44)	39.61%	49.53%	42.63%	44.14%	44.60%	46.12%	43.32%	44.51%	44.31%	44.77%
Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21-44)	3.09%	5.52%	1.18%	5.69%	9.69%	8.88%	5.50%	3.71%	5.41%	5.74%
Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21-44)	9.47%	13.54%	6.94%	12.35%	15.49%	14.87%	11.73%	11.40%	11.97%	12.42%

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15-44)	13.97%	19.35%	16.30%	17.50%	24.35%	23.14%	17.95%	16.36%	18.61%	18.99%
Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15-44)	39.79%	50.17%	42.61%	44.41%	45.04%	46.39%	42.88%	44.76%	44.51%	45.01%
Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15-44)	3.18%	6.23%	1.46%	5.87%	10.46%	9.19%	5.67%	3.85%	5.74%	6.08%
Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15-44)	9.49%	14.29%	7.19%	12.68%	16.31%	15.31%	12.05%	11.71%	12.38%	12.85%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%) (HPCMI-AD)										
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%): Ages 18-64 years[2]	83.33%	82.40%	87.07%	64.90%	90.59%	96.00%	92.96%	75.54%	74.76%	82.50%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%): Ages 65-75 years[2]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	62.22%	78.05%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%): Ages: Total[2]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	74.72%	82.48%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)										
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1-11 years	60.95%	68.34%	77.34%	68.10%	67.65%	67.65%	70.37%	62.20%	60.29%	67.74%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 12-17 years	59.51%	66.49%	62.35%	66.67%	73.58%	55.65%	60.50%	66.78%	56.84%	63.82%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages Total	60.00%	67.13%	69.00%	67.09%	72.14%	58.86%	63.35%	65.30%	58.10%	65.10%
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence (FUA)										
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 18-64 (7 days)	20.72%	16.58%	19.40%	19.51%	25.79%	26.60%	20.80%	20.53%	18.88%	21.76%
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 18-64 (30 days)	28.89%	24.31%	30.49%	28.11%	34.75%	36.52%	30.56%	33.02%	27.41%	31.47%

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 65+ (7 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9.26%	11.76%
Follow-Up after Emergency Department (ED) Visit for Alcohol and other Drug Abuse or Dependence: Ages 65+ (30 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9.26%	11.76%
Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM)										
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 18-64 (7 days)	43.01%	39.55%	61.55%	43.04%	47.49%	39.19%	36.42%	37.33%	38.62%	42.41%
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 18-64 (30 days)	54.15%	55.24%	70.90%	57.30%	56.01%	49.78%	48.21%	53.11%	49.41%	55.14%
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 65+ (7 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30.56%	85.71%
Follow-up After Emergency Department (ED) Visit for Mental Illness: Ages 65+ (30 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30.56%	85.71%
Concurrent Use of Opioids and Benzodiazepines (COB)										
Concurrent Use of Opioids and Benzodiazepines: Ages 18-64 years	12.01%	23.24%	21.96%	19.44%	15.41%	23.01%	12.91%	16.98%	18.12%	18.64%
Concurrent Use of Opioids and Benzodiazepines: Ages 65+	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11.61%	9.59%
Concurrent Use of Opioids and Benzodiazepines: Ages: Total	12.04%	23.14%	22.04%	19.33%	15.33%	22.99%	12.90%	16.96%	18.09%	18.61%
Adult Annual Dental Visit ≥ 21 Years (AADV)										
Adult Annual Dental Visit ≥ 21 Years: (Ages 21-35 years)	21.67%	29.50%	27.25%	28.29%	26.95%	30.02%	25.11%	27.72%	27.06%	27.39%
Adult Annual Dental Visit ≥ 21 Years: (Ages 36-59 years)	20.38%	26.35%	25.17%	25.62%	25.33%	27.21%	23.23%	24.54%	24.73%	25.02%
Adult Annual Dental Visit ≥ 21 Years: (Ages 60-64 years)	18.12%	21.78%	21.25%	20.29%	22.53%	23.44%	19.47%	21.70%	21.07%	21.43%
Adult Annual Dental Visit ≥ 21 Years: (Ages 65+ years)	12.83%	17.08%	11.27%	14.77%	14.80%	16.36%	13.90%	14.53%	14.44%	15.03%
Adult Annual Dental Visit ≥ 21 Years: (Ages Total)	20.79%	27.31%	25.71%	26.33%	25.70%	28.00%	23.75%	25.59%	25.40%	25.71%
Adult Annual Dental Visit: Women with a Live Birth (21-35 years)	24.70%	30.02%	28.16%	28.63%	30.76%	31.72%	26.94%	28.72%	28.71%	29.08%
Adult Annual Dental Visit: Women with a Live Birth (36-59 years)	24.91%	29.75%	24.07%	30.79%	34.48%	31.40%	28.29%	28.95%	29.08%	29.69%

PH-MCO PAPMs	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Adult Annual Dental Visit: Women with a Live Birth (21-59 years)	24.72%	29.99%	27.73%	28.84%	31.22%	31.68%	27.08%	28.75%	28.75%	29.15%
Use of Pharmacotherapy for Opioid Use Disorder (OUD)										
Use of Pharmacotherapy for Opioid Use Disorder: Total	75.44%	74.01%	78.66%	77.34%	55.82%	65.16%	78.30%	80.16%	64.99%	75.21%
Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine	67.98%	68.72%	74.29%	72.79%	52.24%	62.77%	73.44%	70.47%	60.30%	69.30%
Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone	6.09%	3.94%	2.96%	3.81%	2.09%	3.40%	4.69%	4.38%	3.48%	3.99%
Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone	9.04%	8.13%	5.01%	7.15%	2.69%	4.15%	7.99%	8.65%	5.87%	7.04%
Use of Pharmacotherapy for Opioid Use Disorder: Methadone	0.39%	0.00%	0.13%	0.09%	3.28%	0.38%	0.69%	8.36%	1.48%	2.52%

[1] For the Adult Admission Rate measures, lower rates indicate better performance.

[2] For the Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (> 9.0%) (HPCMI-AD), lower rates indicate better performance.

CHIP-MCO Performance Measures

Each CHIP-MCO underwent a full HEDIS Compliance Audit in 2021. Each year, DHS updates its requirements for the CHIP-MCOs to be consistent with NCQA's requirement for the reporting year. CHIP-MCOs are required to report the complete set of CHIP measures mandated by DHS, as specified in the *HEDIS MY 2020: Volume 2: Technical Specifications*. All CHIP-MCO HEDIS rates are compiled and provided to DHS CHIP on an annual basis. The individual MCO 2021 (MY 2020) EQR reports include these measures. **Table 6a** represents the HEDIS performance for all 10 CHIP-MCOs in 2021, as well as the CHIP mean and the CHIP weighted average; this table includes the full set of HEDIS MY 2020 measures reported to DHS CHIP. If the denominator was less than 30 for a particular rate, "N/A" (Not Applicable) appears in the corresponding cells.

Table 6a: CHIP-MCO Results for 2021 (MY 2020) HEDIS Measures

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
Effectiveness of Care													
Prevention and Screening													
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) - Hybrid													
WCC: BMI Ages 3 - 11 years	75.94%	85.34%	86.75%	82.78%	82.99%	84.76%	81.43%	76.00%	90.46%	80.93%	82.74%	83.39%	▼
WCC: BMI Ages 12 - 17 years	75.86%	77.91%	86.98%	75.19%	81.56%	85.11%	75.64%	79.14%	88.82%	77.95%	80.42%	80.66%	▼
WCC: BMI Ages 3 - 17 years Total Rate	75.91%	81.92%	86.87%	79.55%	82.29%	84.92%	78.96%	77.64%	89.78%	79.75%	81.76%	82.25%	▼

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
WCC: Nutrition Ages 3 - 11 years	77.82%	69.63%	75.30%	82.78%	79.59%	76.83%	78.57%	72.67%	86.72%	78.35%	77.83%	78.97%	▼
WCC: Nutrition Ages 12 - 17 years	72.41%	64.42%	79.29%	70.68%	73.05%	77.30%	69.23%	74.85%	83.53%	77.95%	74.27%	75.42%	▼
WCC: Nutrition Ages 3 - 17 years Total Rate	75.91%	67.23%	77.31%	77.64%	76.39%	77.05%	74.59%	73.80%	85.40%	78.19%	76.35%	77.53%	▼
WCC: Physical Activity Ages 3 - 11 years	74.44%	67.54%	75.90%	70.56%	77.55%	75.00%	73.81%	68.67%	82.16%	78.35%	74.40%	76.10%	▲
WCC: Physical Activity Ages 12 - 17 years	71.72%	65.03%	82.25%	66.17%	76.60%	76.60%	67.95%	76.07%	84.12%	76.38%	74.29%	75.17%	▼
WCC: Physical Activity Ages 3 - 17 Total Rate	73.48%	66.38%	79.10%	68.69%	77.08%	75.74%	71.31%	72.52%	82.97%	77.57%	74.48%	75.79%	▲
Childhood Immunization Status (CIS) - Hybrid													
CIS: DTaP	91.54%	86.42%	87.79%	88.60%	78.00%	86.44%	82.68%	85.00%	89.54%	85.89%	86.19%	87.18%	▼
CIS: IPV	96.15%	94.44%	92.96%	94.74%	92.00%	91.53%	89.39%	91.67%	94.89%	92.21%	93.00%	93.25%	▲
CIS: MMR	96.92%	94.44%	92.96%	91.23%	88.00%	91.53%	88.83%	90.00%	94.65%	91.73%	92.03%	92.81%	▲
CIS: HiB	96.15%	91.98%	91.08%	95.61%	90.00%	90.68%	89.94%	93.33%	93.92%	92.94%	92.56%	93.01%	▲
CIS: Hepatitis B	94.23%	93.21%	91.08%	91.23%	90.00%	88.98%	86.03%	86.67%	94.65%	93.19%	90.93%	92.41%	▲
CIS: VZV	96.54%	91.98%	90.61%	92.11%	88.00%	89.83%	84.92%	90.00%	94.16%	91.48%	90.96%	91.91%	▼
CIS: Pneumococcal Conjugate	91.92%	87.04%	86.85%	85.09%	84.00%	84.75%	81.56%	90.00%	91.48%	89.78%	87.25%	88.79%	▲
CIS: Hepatitis A	93.08%	88.27%	83.57%	89.47%	82.00%	86.44%	85.47%	78.33%	91.73%	90.51%	86.89%	89.25%	▲
CIS: Rotavirus	85.38%	72.22%	80.28%	77.19%	82.00%	78.81%	76.54%	81.67%	84.18%	83.45%	80.17%	81.75%	▲
CIS: Influenza	69.62%	57.41%	58.69%	59.65%	66.00%	55.93%	66.48%	63.33%	68.13%	63.75%	62.90%	64.12%	▲
CIS: Combination 2	89.62%	83.33%	84.04%	83.33%	78.00%	82.20%	79.33%	78.33%	87.10%	81.51%	82.68%	83.67%	▼
CIS: Combination 3	88.08%	80.25%	82.63%	79.82%	78.00%	78.81%	75.98%	78.33%	86.37%	80.29%	80.86%	82.08%	▲
CIS: Combination 4	86.54%	77.16%	77.93%	77.19%	74.00%	76.27%	75.42%	73.33%	84.18%	78.83%	78.09%	79.91%	▲
CIS: Combination 5	80.77%	66.05%	73.71%	70.18%	74.00%	72.03%	69.83%	75.00%	78.83%	73.97%	73.44%	74.63%	▲
CIS: Combination 6	66.15%	51.85%	54.93%	52.63%	64.00%	50.00%	61.45%	56.67%	63.75%	57.66%	57.91%	59.00%	▲
CIS: Combination 7	79.23%	64.81%	69.95%	67.54%	70.00%	69.49%	69.27%	73.33%	77.37%	72.99%	71.40%	73.05%	▲
CIS: Combination 8	65.77%	50.62%	53.05%	51.75%	60.00%	49.15%	61.45%	55.00%	62.53%	56.69%	56.60%	57.95%	▲
CIS: Combination 9	60.77%	44.44%	51.17%	46.49%	60.00%	45.76%	55.87%	56.67%	58.64%	52.80%	53.26%	54.02%	▲
CIS: Combination 10	60.38%	43.83%	50.23%	45.61%	56.00%	44.92%	55.87%	55.00%	57.91%	52.07%	52.18%	53.27%	▲
Immunizations for Adolescents (IMA) - Hybrid													
IMA: Meningococcal	88.56%	89.54%	91.24%	91.73%	93.83%	94.16%	91.97%	87.76%	91.24%	90.02%	91.01%	90.86%	▼
IMA: Tdap/Td	88.32%	91.48%	90.02%	92.21%	93.57%	93.67%	91.24%	88.46%	91.97%	92.21%	91.32%	91.47%	▼
IMA: HPV	35.52%	38.20%	35.28%	42.34%	33.68%	33.33%	37.23%	33.92%	44.28%	38.20%	37.20%	38.36%	▲

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
IMA: Combination 1	87.10%	88.81%	89.29%	91.24%	93.06%	92.46%	90.27%	86.71%	90.27%	89.78%	89.90%	89.85%	▼
IMA: Combination 2	34.55%	36.74%	35.04%	41.85%	33.42%	32.60%	36.25%	32.52%	43.31%	37.71%	36.40%	37.57%	▲
Lead Screening in Children (LSC) - Hybrid													
LSC: Rate	74.62%	45.68%	72.77%	79.82%	58.00%	56.78%	57.54%	53.33%	79.81%	85.64%	66.40%	74.69%	▲
Chlamydia Screening in Women (CHL)													
CHL: Ages 16 - 19 years	38.85%	31.03%	39.78%	52.07%	39.38%	25.77%	44.81%	30.18%	38.53%	36.38%	37.68%	37.75%	▼
Respiratory Conditions													
Asthma Medication Ratio (AMR)													
AMR: 5 - 11 years	78.79%	90.70%	90.79%	74.68%	83.33%	90.00%	64.52%	N/A	82.63%	84.95%	82.27%	81.32%	▲
AMR: 12 - 18 years	72.50%	71.84%	82.26%	70.97%	66.67%	83.87%	65.56%	73.17%	69.19%	69.95%	72.60%	71.20%	▲
AMR: 19 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
AMR: Total	75.98%	80.53%	87.14%	73.05%	72.41%	86.41%	65.22%	75.00%	76.10%	77.04%	76.89%	76.09%	▲
Appropriate Testing for Pharyngitis (CWP)													
CWP: 3 - 17 years	86.53%	85.61%	85.41%	84.09%	88.84%	84.17%	87.14%	80.74%	86.45%	88.78%	85.78%	86.67%	▼
CWP: 18 years	N/A	64.71%	71.43%	N/A	N/A	N/A	77.78%	N/A	72.83%	75.00%	72.35%	72.95%	▼
CWP: Total Rate	86.07%	84.79%	84.91%	83.66%	88.65%	84.38%	86.79%	79.75%	85.89%	88.41%	85.33%	86.22%	▼
Appropriate Treatment for Upper Respiratory Infection (URI)													
URI: 3 - 17 years	94.71%	94.01%	92.84%	94.67%	91.12%	94.82%	94.87%	89.70%	94.03%	92.34%	93.31%	93.48%	▲
URI: 18 years	86.49%	89.29%	75.00%	N/A	95.00%	95.56%	87.50%	N/A	91.30%	84.77%	88.11%	87.50%	▲
URI: Total Rate	94.57%	93.86%	92.29%	94.72%	91.30%	94.84%	94.67%	89.68%	93.96%	92.12%	93.20%	93.32%	▲
Behavioral Health													
Follow-up Care for Children Prescribed ADHD Medication (ADD)													
ADD: Initiation Phase	46.36%	39.39%	40.74%	51.06%	48.15%	48.25%	28.85%	52.94%	54.55%	58.02%	46.83%	48.96%	▼
ADD: Continuation and Maintenance Phase	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	62.16%	76.71%	69.44%	71.82%	▲
Follow up After Hospitalization for Mental Illness (FUH)													
FUH: 7 Days	45.61%	60.00%	50.94%	N/A	N/A	71.70%	57.81%	60.00%	46.15%	58.11%	56.29%	55.24%	▲
FUH: 30 Days	61.40%	90.00%	64.15%	N/A	N/A	90.57%	67.19%	90.00%	70.09%	81.08%	76.81%	75.87%	▲
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)													
APM: Blood Glucose Testing Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
APM: Blood Glucose Testing Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53.70%	53.70%	53.70%	▼
APM: Blood Glucose Testing Total Rate	N/A	N/A	69.70%	N/A	N/A	51.61%	N/A	N/A	N/A	53.85%	58.39%	57.37%	▼
APM: Cholesterol Testing Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
APM: Cholesterol Testing Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	24.07%	24.07%	24.07%	▼
APM: Cholesterol Testing Total Rate	N/A	N/A	48.48%	N/A	N/A	29.03%	N/A	N/A	N/A	30.77%	36.09%	34.88%	▼
APM: Blood Glucose & Cholesterol Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
APM: Blood Glucose & Cholesterol Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	22.22%	22.22%	22.22%	▼
APM: Blood Glucose & Cholesterol Total Rate	N/A	N/A	48.48%	N/A	N/A	25.81%	N/A	N/A	N/A	26.15%	33.48%	31.78%	▼
Access/Availability of Care													
Annual Dental Visits (ADV)													
ADV: Ages 2 - 3 years	42.31%	30.85%	29.69%	47.28%	25.70%	28.84%	48.98%	30.70%	36.21%	31.95%	35.25%	35.84%	▼
ADV: Ages 4 - 6 years	60.98%	59.56%	55.96%	61.95%	53.93%	60.94%	69.66%	58.42%	61.86%	60.88%	60.41%	61.29%	▼
ADV: Ages 7 - 10 years	60.32%	63.57%	59.03%	64.55%	59.82%	63.08%	69.49%	62.91%	61.74%	61.85%	62.64%	62.67%	▲
ADV: Ages 11 - 14 years	58.75%	62.72%	54.24%	60.58%	62.88%	60.40%	65.63%	60.97%	60.52%	56.72%	60.34%	60.00%	▼
ADV: Ages 15 - 18 years	48.60%	54.56%	43.75%	48.04%	57.21%	56.01%	55.21%	55.78%	50.19%	48.42%	51.78%	51.03%	▼
ADV: Ages 19 years	30.39%	29.03%	39.66%	26.92%	41.46%	60.00%	44.05%	NA	50.42%	32.35%	39.36%	38.30%	▼
ADV: Ages 2-19 years Total Rate	55.59%	58.30%	51.43%	57.79%	57.35%	57.98%	63.20%	57.93%	56.81%	54.74%	57.11%	56.89%	▲
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)													
APP: Ages 1 - 11 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
APP: Ages 12 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	71.74%	71.74%	71.74%	▲
APP: Ages 1 - 17 years Total Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	67.31%	67.31%	67.31%	▲
Use of Services													
Well-Child Visits in the First 30 Months of Life (W30)													
W30: ≥ 6 visits 15 months	34.15%	62.32%	63.75%	58.06%	N/A	70.00%	46.43%	N/A	44.50%	78.16%	57.17%	60.28%	▼
W30: ≥ 2 visits 30 months	90.15%	89.50%	85.06%	85.42%	88.71%	90.13%	87.60%	90.28%	88.56%	92.09%	88.75%	89.54%	
Child and Adolescent Well-Care Visits (WCV)													
WCV: 3 - 11 years	63.40%	64.71%	64.65%	60.73%	67.04%	65.61%	67.67%	62.28%	65.57%	68.87%	65.05%	65.85%	

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
WCV: 12 - 17 years	57.86%	63.25%	61.56%	59.69%	66.28%	63.72%	63.57%	64.62%	60.88%	64.86%	62.63%	62.51%	
WCV: 18 - 19 years	46.40%	48.64%	50.53%	51.24%	54.31%	47.76%	54.06%	50.46%	50.68%	53.27%	50.74%	51.06%	
WCV: 3 - 19 years	60.08%	62.91%	62.48%	59.65%	65.55%	63.63%	64.87%	62.41%	62.74%	66.26%	63.06%	63.46%	
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)													
FUI: 30 days 13 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
FUI: 30 days 18 - 19 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
FUI: 30 days 13 - 19 years Total Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
FUI: 7 days 13 - 17 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
FUI: 7 days 18 - 19 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
FUI: 7 days 13 - 19 years Total Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Pharmacotherapy for Opioid Use Disorder (POD)													
POD: 16 - 19 years	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Ambulatory Care: Total (AMBA)													
AMBA: Outpatient Visits/1000 MM Ages <1 year	537.22	582.30	533.00	440.89	590.55	589.91	571.67	640.45	535.38	773.57	579.49	613.82	▼
AMBA: Outpatient Visits/1000 MM Ages 1 - 9 years	169.93	187.36	203.24	137.30	199.69	216.12	156.77	202.04	183.92	263.00	191.94	198.85	▼
AMBA: Outpatient Visits/1000 MM Ages 10 - 19 years	151.26	190.67	205.43	127.73	212.38	214.28	142.91	201.33	174.38	239.31	185.97	187.19	▼
AMBA: Outpatient Visits/1000 MM Ages <1 - 19 years Total Rate	164.01	191.70	206.76	133.46	209.95	217.74	151.33	203.94	181.45	255.94	191.63	195.78	▼
AMBA: Emergency Department Visits/1000 MM Ages <1 year	25.93	37.17	22.28	30.60	40.94	8.41	16.06	22.47	20.17	23.76	24.78	23.50	▼
AMBA: Emergency Department Visits/1000 MM Ages 1 - 9 years	16.05	13.31	15.99	16.45	18.32	14.07	15.74	16.42	17.13	17.69	16.12	16.36	▼
AMBA: Emergency Department Visits/1000 MM Ages 10 - 19 years	14.03	13.25	17.19	12.49	18.43	12.83	13.37	18.07	15.15	18.13	15.29	15.35	▼
AMBA: Emergency Department Visits/1000 MM Ages <1 - 19 years Total Rate	15.06	13.42	16.69	14.25	18.53	13.32	14.34	17.45	16.07	18.00	15.71	15.85	▼

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)													
IPUA: Total Discharges/1000 MM Ages <1 year	0.67	0.00	4.13	0.00	0.00	3.15	0.00	0.00	0.00	3.96	1.19		
IPUA: Total Discharges/1000 MM Ages 1 - 9 years	0.26	0.29	0.61	0.29	0.47	0.39	0.61	0.23	0.45	0.61	0.42		
IPUA: Total Discharges/1000 MM Ages 10 - 19 years	0.45	0.51	0.67	0.61	0.74	0.68	0.91	0.59	0.76	0.83	0.68		
IPUA: Total Discharges/1000 MM Ages <1 - 19 years Total Rate	0.37	0.41	0.67	0.47	0.64	0.57	0.79	0.45	0.61	0.77	0.58		
IPUA: Total Inpatient ALOS Ages <1 year	3.00	N/A	2.00	N/A	N/A	7.33	N/A	N/A	N/A	2.29	3.66		
IPUA: Total Inpatient ALOS Ages 1 - 9 years	3.90	4.18	3.04	2.31	2.44	3.59	2.80	2.67	3.51	2.46	3.09		
IPUA: Total Inpatient ALOS Ages 10 - 19 years	3.78	4.08	5.05	2.48	4.49	4.84	2.91	4.04	3.55	3.53	3.88		
IPUA: Total Inpatient ALOS Ages <1 - 19 years Total Rate	3.80	4.11	4.10	2.44	3.93	4.58	2.87	3.77	3.54	3.08	3.62		
IPUA: Surgery Discharges/1000 MM Ages <1 year	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.94	0.09		
IPUA: Surgery Discharges/1000 MM Ages 1 - 9 years	0.10	0.10	0.17	0.05	0.21	0.12	0.12	0.04	0.10	0.23	0.12		
IPUA: Surgery Discharges/1000 MM Ages 10 - 19 years	0.14	0.18	0.18	0.16	0.36	0.28	0.26	0.20	0.22	0.35	0.23		
IPUA: Surgery Discharges/1000 MM Ages <1 - 19 years Total Rate	0.12	0.15	0.17	0.11	0.30	0.21	0.20	0.14	0.17	0.30	0.19		
IPUA: Surgery ALOS Ages <1 year	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3.00	3.00		
IPUA: Surgery ALOS Ages 1 - 9 years	6.45	6.13	4.77	2.67	2.86	6.57	4.23	4.00	6.16	3.44	4.73		
IPUA: Surgery ALOS Ages 10 - 19 years	4.89	5.37	8.94	3.42	6.43	5.29	3.13	2.50	3.49	4.48	4.79		
IPUA: Surgery ALOS Ages <1 - 19 years Total Rate	5.47	5.59	7.13	3.27	5.54	5.61	3.40	2.67	4.21	4.07	4.70		
IPUA: Medicine Discharges/1000 MM Ages <1 year	0.67	0.00	4.13	0.00	0.00	3.15	0.00	0.00	0.00	3.02	1.10		
IPUA: Medicine Discharges/1000 MM Ages 1 - 9 years	0.17	0.18	0.44	0.24	0.26	0.26	0.48	0.20	0.34	0.38	0.30		
IPUA: Medicine Discharges/1000 MM Ages 10 - 19 years	0.20	0.22	0.38	0.42	0.21	0.33	0.60	0.35	0.43	0.41	0.36		

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
IPUA: Medicine Discharges/1000 MM Ages <1 - 19 years Total Rate	0.19	0.20	0.44	0.34	0.23	0.32	0.55	0.29	0.39	0.43	0.34		
IPUA: Medicine ALOS Ages <1 year	3.00	N/A	2.00	N/A	N/A	7.33	N/A	N/A	N/A	2.06	3.60		
IPUA: Medicine ALOS Ages 1 - 9 years	2.42	3.07	2.38	2.23	2.11	2.20	2.43	2.40	2.72	1.86	2.38		
IPUA: Medicine ALOS Ages 10 - 19 years	3.86	3.91	3.83	2.13	3.00	4.92	2.88	5.29	3.86	2.92	3.66		
IPUA: Medicine ALOS Ages <1 - 19 years Total Rate	3.27	3.59	3.05	2.16	2.62	4.14	2.72	4.53	3.41	2.44	3.19		
IPUA: Maternity/1000 MM Ages 10 - 19 years	0.11	0.11	0.11	0.03	0.17	0.07	0.06	0.05	0.10	0.07	0.09		
IPUA: Maternity ALOS Ages 10 - 19 years Total Rate	2.31	2.18	2.80	2.50	2.20	2.60	2.22	1.50	2.42	2.44	2.32		
Mental Health Utilization (MPT)													
MPT: Any Services Ages 0 - 12 years - Male	3.32%	6.12%	7.59%	2.42%	10.18%	8.37%	3.99%	7.01%	4.87%	10.19%	6.41%		
MPT: Any Services Ages 0 - 12 years - Female	2.63%	4.79%	5.60%	2.14%	8.51%	7.29%	3.16%	6.43%	3.56%	8.19%	5.23%		
MPT: Any Services Ages 0 - 12 years - Total Rate	2.98%	5.46%	6.61%	2.28%	9.35%	7.83%	3.58%	6.73%	4.21%	9.20%	5.82%		
MPT: Any Services Ages 13 - 17 years - Male	4.68%	6.95%	10.16%	3.27%	11.11%	10.24%	6.40%	9.63%	6.87%	12.95%	8.23%		
MPT: Any Services Ages 13 - 17 years - Female	7.57%	13.21%	17.07%	5.91%	23.88%	20.18%	10.78%	18.44%	12.38%	23.14%	15.26%		
MPT: Any Services Ages 13 - 17 years - Total Rate	6.12%	10.12%	13.61%	4.61%	17.52%	15.15%	8.63%	14.03%	9.61%	18.03%	11.74%		
MPT: Inpatient Ages 0 - 12 years - Male	0.06%	0.08%	0.11%	0.06%	0.00%	0.11%	0.03%	0.06%	0.09%	0.09%	0.07%		
MPT: Inpatient Ages 0 - 12 years - Female	0.06%	0.19%	0.13%	0.09%	0.18%	0.20%	0.11%	0.13%	0.14%	0.15%	0.14%		
MPT: Inpatient Ages 0 - 12 years - Total Rate	0.06%	0.14%	0.12%	0.07%	0.09%	0.16%	0.07%	0.09%	0.12%	0.12%	0.10%		
MPT: Inpatient Ages 13 - 17 years – Male	0.31%	0.29%	0.28%	0.48%	0.29%	0.84%	0.45%	0.10%	0.43%	0.63%	0.41%		
MPT: Inpatient Ages 13 - 17 years - Female	1.22%	0.85%	1.59%	0.65%	1.16%	1.79%	1.08%	2.31%	1.26%	1.41%	1.33%		
MPT: Inpatient Ages 13 - 17 years - Total Rate	0.77%	0.58%	0.93%	0.57%	0.73%	1.31%	0.77%	1.20%	0.84%	1.02%	0.87%		
MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Male	0.17%	0.04%	0.02%	0.12%	0.05%	0.06%	0.07%	0.00%	0.10%	0.05%	0.07%		
MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Female	0.09%	0.13%	0.09%	0.14%	0.00%	0.14%	0.18%	0.00%	0.05%	0.08%	0.09%		

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Total Rate	0.13%	0.08%	0.05%	0.13%	0.02%	0.10%	0.13%	0.00%	0.08%	0.06%	0.08%		
MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Male	0.47%	0.25%	0.05%	0.12%	0.15%	0.28%	0.39%	0.10%	0.17%	0.22%	0.22%		
MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Female	0.75%	0.85%	0.23%	0.53%	0.36%	0.92%	0.84%	0.00%	0.82%	1.03%	0.63%		
MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Total Rate	0.61%	0.56%	0.14%	0.33%	0.25%	0.60%	0.62%	0.05%	0.49%	0.63%	0.43%		
MPT: Outpatient Ages 0 - 12 years - Male	2.64%	5.26%	6.10%	2.16%	8.68%	6.71%	3.14%	5.93%	3.98%	8.89%	5.35%		
MPT: Outpatient Ages 0 - 12 years - Female	1.97%	3.85%	4.46%	1.70%	6.72%	5.83%	2.13%	5.61%	2.74%	7.01%	4.20%		
MPT: Outpatient Ages 0 - 12 years - Total Rate	2.31%	4.55%	5.29%	1.93%	7.70%	6.27%	2.64%	5.78%	3.36%	7.96%	4.78%		
MPT: Outpatient Ages 13 - 17 years - Male	3.84%	6.20%	8.29%	2.61%	9.21%	8.50%	4.83%	8.48%	5.59%	11.33%	6.89%		
MPT: Outpatient Ages 13 - 17 years - Female	5.63%	10.45%	13.53%	4.50%	19.45%	16.72%	7.61%	16.45%	9.67%	19.56%	12.36%		
MPT: Outpatient Ages 13 - 17 years - Total Rate	4.73%	8.35%	10.91%	3.56%	14.35%	12.56%	6.24%	12.46%	7.62%	15.44%	9.62%		
MPT: ED Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%		
MPT: ED Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.00%	0.00%		
MPT: ED Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.01%	0.00%	0.00%		
MPT: ED Ages 13 - 17 years - Male	0.03%	0.00%	0.05%	0.00%	0.07%	0.00%	0.00%	0.10%	0.00%	0.00%	0.03%		
MPT: ED Ages 13 - 17 years - Female	0.00%	0.00%	0.05%	0.00%	0.00%	0.06%	0.00%	0.00%	0.10%	0.05%	0.03%		
MPT: ED Ages 13 - 17 years - Total Rate	0.02%	0.00%	0.05%	0.00%	0.04%	0.03%	0.00%	0.05%	0.05%	0.03%	0.03%		
MPT: Telehealth Ages 0 - 12 years - Male	1.39%	2.59%	4.15%	0.73%	5.12%	4.74%	2.10%	3.48%	2.32%	5.21%	3.18%		
MPT: Telehealth Ages 0 - 12 years - Female	1.58%	2.35%	3.02%	0.92%	4.85%	4.29%	1.90%	3.47%	1.92%	4.86%	2.92%		
MPT: Telehealth Ages 0 - 12 years - Total Rate	1.48%	2.47%	3.60%	0.83%	4.98%	4.52%	2.00%	3.47%	2.12%	5.04%	3.05%		
MPT: Telehealth Ages 13 - 17 years - Male	1.75%	3.00%	4.98%	1.09%	5.41%	5.23%	3.67%	5.13%	3.53%	6.90%	4.07%		
MPT: Telehealth Ages 13 - 17 years - Female	3.72%	7.56%	11.38%	2.66%	14.95%	12.91%	6.72%	11.00%	7.63%	14.70%	9.32%		

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
MPT: Telehealth Ages 13 - 17 years - Total Rate	2.73%	5.31%	8.18%	1.89%	10.20%	9.03%	5.22%	8.06%	5.57%	10.79%	6.70%		
Identification of Alcohol and Other Drug Services (IAD)													
IAD: Any Services Ages 0 - 12 years - Male	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.00%	0.04%	0.05%	0.01%		
IAD: Any Services Ages 0 - 12 years - Female	0.01%	0.02%	0.00%	0.00%	0.05%	0.00%	0.05%	0.13%	0.03%	0.02%	0.03%		
IAD: Any Services Ages 0 - 12 years - Total Rate	0.01%	0.01%	0.00%	0.00%	0.02%	0.00%	0.04%	0.06%	0.03%	0.04%	0.02%		
IAD: Any Services Ages 13 - 17 years - Male	0.97%	0.83%	0.98%	0.55%	1.39%	0.84%	0.93%	0.73%	1.00%	1.15%	0.94%		
IAD: Any Services Ages 13 - 17 years - Female	0.66%	0.45%	1.03%	0.30%	0.73%	1.33%	0.68%	0.94%	0.63%	1.00%	0.78%		
IAD: Any Services Ages 13 - 17 years - Total Rate	0.81%	0.64%	1.00%	0.42%	1.06%	1.08%	0.80%	0.84%	0.82%	1.07%	0.85%		
IAD: Inpatient Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.01%	0.02%	0.00%		
IAD: Inpatient Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.01%	0.00%	0.00%		
IAD: Inpatient Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.01%	0.01%	0.00%		
IAD: Inpatient Ages 13 - 17 years - Male	0.16%	0.29%	0.19%	0.30%	0.15%	0.28%	0.17%	0.10%	0.15%	0.33%	0.21%		
IAD: Inpatient Ages 13 - 17 years – Female	0.31%	0.08%	0.56%	0.00%	0.15%	0.40%	0.14%	0.31%	0.23%	0.29%	0.25%		
IAD: Inpatient Ages 13 - 17 years - Total Rate	0.23%	0.19%	0.37%	0.15%	0.15%	0.34%	0.15%	0.21%	0.19%	0.31%	0.23%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Male	0.03%	0.00%	0.00%	0.06%	0.00%	0.06%	0.11%	0.00%	0.04%	0.03%	0.03%		
IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Female	0.03%	0.08%	0.05%	0.00%	0.00%	0.00%	0.03%	0.00%	0.00%	0.07%	0.03%		

CHIP MCO HEDIS Measure	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	PA CHIP MEAN	PA CHIP Weighted Average	
IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Total Rate	0.03%	0.04%	0.02%	0.03%	0.00%	0.03%	0.07%	0.00%	0.02%	0.05%	0.03%		
IAD: Outpatient Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.03%	0.01%		
IAD: Outpatient Ages 0 - 12 years - Female	0.01%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.06%	0.00%	0.02%	0.01%		
IAD: Outpatient Ages 0 - 12 years - Total Rate	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.01%	0.02%	0.01%		
IAD: Outpatient Ages 13 - 17 years - Male	0.44%	0.29%	0.47%	0.00%	0.88%	0.39%	0.50%	0.73%	0.55%	0.70%	0.50%		
IAD: Outpatient Ages 13 - 17 years - Female	0.25%	0.20%	0.33%	0.12%	0.44%	0.63%	0.14%	0.52%	0.15%	0.46%	0.32%		
IAD: Outpatient Ages 13 - 17 years - Total Rate	0.34%	0.25%	0.40%	0.06%	0.66%	0.51%	0.32%	0.63%	0.35%	0.58%	0.41%		
IAD: ED Ages 0 - 12 years - Male	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.01%	0.00%		
IAD: ED Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.05%	0.00%	0.03%	0.00%	0.02%	0.00%	0.01%		
IAD: ED Ages 0 - 12 years - Total Rate	0.01%	0.00%	0.00%	0.00%	0.02%	0.00%	0.02%	0.00%	0.01%	0.00%	0.01%		
IAD: ED Ages 13 - 17 years - Male	0.41%	0.42%	0.33%	0.18%	0.51%	0.28%	0.28%	0.10%	0.38%	0.21%	0.31%		
IAD: ED Ages 13 - 17 years - Female	0.22%	0.12%	0.42%	0.24%	0.22%	0.40%	0.35%	0.21%	0.31%	0.38%	0.29%		
IAD: ED Ages 13 - 17 years - Total Rate	0.31%	0.27%	0.37%	0.21%	0.36%	0.34%	0.32%	0.16%	0.34%	0.29%	0.30%		
IAD: Telehealth Ages 0 - 12 years - Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	0.00%		
IAD: Telehealth Ages 0 - 12 years - Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.06%	0.00%	0.01%	0.01%		
IAD: Telehealth Ages 0 - 12 years - Total Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.01%	0.01%	0.01%		
IAD: Telehealth Ages 13 - 17 years - Male	0.16%	0.17%	0.42%	0.00%	0.15%	0.23%	0.11%	0.63%	0.23%	0.38%	0.25%		
IAD: Telehealth Ages 13 - 17 years - Female	0.09%	0.12%	0.23%	0.00%	0.29%	0.46%	0.14%	0.21%	0.04%	0.34%	0.19%		
IAD: Telehealth Ages 13 - 17 years - Total Rate	0.12%	0.14%	0.33%	0.00%	0.22%	0.34%	0.12%	0.42%	0.13%	0.36%	0.22%		

Note: Gray shading indicates IPRO does not provide or calculate these rates.

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

- A description of each PAPM,
- The MCO's review year rates with 95% upper and lower confidence intervals (95% CI),

- Two years of data (the MY and previous year) and the MMC rate, and
- Comparisons to the MCO's previous year rate and to the MMC rate.

Results for PAPMs are presented for each CHIP-MCO in **Table 6b**, along with the CHIP average and CHIP weighted average, which takes into account the proportional relevance of each MCO.

Table 6b: CHIP-MCO Results for 2021 (MY 2020) PAPMs

CHIP MCO PAPMs	ABH	CBC	GEI	HPP	Highmark HMO	Highmark PPO	IBC	NEPA	UHC	UPMC	CHIP Average	CHIP Weighted Average
Annual Number of Asthma Patients with One or More Asthma-Related Emergency Rooms Visits												
Rate[1]	10.83%	2.87%	3.37%	10.36%	7.84%	3.54%	8.59%	7.89%	7.38%	6.25%	6.89%	7.08%
Contraceptive Care for Postpartum Women Ages 15-20 Years												
Most or moderately effective contraception-3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Most or moderately effective contraception-60 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LARC - 3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LARC - 60 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contraceptive Care for Women Ages 15-20 Years												
Provision of most or moderately effective contraception	17.21%	27.57%	30.99%	17.09%	35.25%	26.43%	19.83%	31.39%	23.18%	30.54%	25.95%	25.40%
Provision of LARC	1.66%	1.67%	1.62%	1.23%	2.44%	2.21%	0.94%	1.26%	1.50%	3.20%	1.77%	1.89%
Dental Sealants on Permanent First Molars (SFM-CH)												
≥ 1 Molar	21.74%	51.28%	44.89%	42.44%	40.12%	39.52%	52.67%	44.40%	36.46%	33.93%	40.75%	38.67%
All 4 Molars	13.86%	39.40%	31.93%	29.87%	31.48%	27.42%	39.44%	33.60%	24.41%	20.71%	29.21%	26.74%
Developmental Screening in the First Three Years of Life												
1 Year	69.66%	53.23%	35.00%	47.83%	N/A	N/A	52.86%	N/A	65.77%	72.26%	56.53%	63.64%
2 Years	73.08%	53.16%	49.29%	59.65%	74.00%	66.10%	73.26%	56.67%	68.11%	77.91%	65.12%	69.10%
3 Years	68.74%	51.09%	49.61%	63.30%	77.07%	62.26%	68.34%	60.44%	62.70%	72.37%	63.59%	64.86%
Total	70.14%	51.87%	48.58%	61.13%	75.56%	63.35%	68.10%	57.76%	64.81%	74.38%	63.57%	66.13%

[1] Lower rate indicates better performance for the Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits.

BH-MCO Performance Measures

PA's HealthChoices BH program does not require BH-MCOs to complete a HEDIS Compliance Audit. BH-MCOs and Primary Contractors are required to calculate PAPMs, which are validated annually by IPRO, to support the MCOs' QAPI Program requirements. For MY 2020, these performance measures were: Follow-up After Hospitalization for Mental Illness (FUH, both HEDIS and PA-specific) and Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA).

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2018 (MY 2017), in part to better account for the growing population of members 65+ years, OMHSAS changed its benchmarking to the FUH All Ages (6+ years) measure. OMHSAS established a three-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 Statewide BBA report. Due to this change in the goal-setting method, no goals were set for MY 2018. Among the updates in 2019 (MY 2018), NCQA added the following reporting strata for FUH, ages: 6-17, 18-64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are now broken into ages: 6-17, 18-64, and 6 and over (All Ages). HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH MCO to complete and submit an RCA and QIP.

To incentivize improvements in its PA PMs, OMHSAS launched in 2020 a P4P program for the HEDIS FUH All Ages and REA measures that determines payments based on performance with respect to certain benchmarks and to improvement over prior year.

MY 2020 performance measure results are presented in **Table 7** for each BH-MCO, along with the BH MMC average and BH MMC weighted average, which takes into account the proportional relevance of each MCO.

Table 7: BH-MCO Results for 2021 (MY 2020) PAPMs

BH-MCO Performance Measure	BHO	CBH	CCBH	MBH	PerformCare	BH MMC Average	BH MMC Weighted Average
HEDIS Follow-up After Hospitalization for Mental Illness							
Within 7 Days – Ages 6-17	60.7%	42.4%	60.6%	43.5%	58.6%	53.2%	55.2%
Within 30 Days – Ages 6-17	84.7%	61.3%	81.2%	70.1%	78.5%	75.2%	77.1%
Within 7 Days – Ages 18-64	41.0%	20.1%	42.7%	35.1%	36.3%	35.1%	36.4%
Within 30 Days – Ages 18-64	62.4%	34.8%	62.3%	55.9%	57.1%	54.5%	55.7%
Within 7 Days – All Ages	45.0%	23.1%	45.9%	36.6%	41.0%	38.3%	39.8%
Within 30 Days – All Ages	67.0%	38.0%	65.7%	58.3%	61.7%	58.1%	59.4%
Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness							
Within 7 Days – All Ages	54.7%	42.0%	57.7%	49.0%	50.0%	50.7%	52.3%
Within 30 Days – All Ages	72.8%	56.8%	73.1%	64.2%	68.6%	67.1%	68.3%
Readmission Within 30 Days of Inpatient Psychiatric Discharge							
Within 30 Days – All Ages	12.8%	14.6%	12.4%	15.6%	13.8%	13.8%	13.6%

- The BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for the HEDIS FUH 7-day All-Ages measure was between the HEDIS 50th and 75th percentiles, while the BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) for the HEDIS FUH 30-day All-Ages measure was between the HEDIS 33rd and 50th percentiles. Consequently, the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for ages 6+ for both 7- and 30-day rates was not achieved. The Primary Contractors that met or exceeded the 75th percentile on at least one of the two measures were: Beaver, Bedford-Somerset, Blair, Chester, Franklin-Fulton, Greene, NBHCC, SWBHM, and York-Adams.
- None of the BH-MCOs met the OMHSAS performance goal of 10% (or lower) for REA.

CHC-MCO Performance Measures

Each CHC-MCO underwent a full HEDIS Compliance Audit in 2021. The CHC-MCOs are required by DHS to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the *HEDIS MY 2020: Volume 2: Technical Specifications*. All the CHC-MCO HEDIS rates are compiled and provided to DHS on an annual basis. **Table 8a** represents the HEDIS performance for all four CHC-MCOs in 2021, as well as the CHC MMC mean and the CHC MMC weighted average.

Comparisons to fee-for-service Medicaid data are not included in this report as the fee-for-service data and processes were not subject to a HEDIS compliance audit for HEDIS MY 2020 measures.

Table 8a, below, summarizes the CHC-MCOs' 2021 (MY 2020) HEDIS performance measure results, with noteworthy findings listed underneath the table.

Table 8a: CHC-MCO Performance Measure Results for 2021 (MY 2020) using HEDIS Technical Specifications

CHC MCO HEDIS Measure	ACP CHC	KF CHC	PAHW	UPMC CHC	PA DHS Mean	Weighted Average
Effectiveness of Care						
Prevention and Screening						
Breast Cancer Screening (BCS)						
BCS: Rate	52.79%	NA	39.35%	65.37%	52.50%	63.94%
Cervical Cancer Screening (CCS)						
CCS: Rate	35.28%	49.39%	25.55%	52.67%	40.72%	46.98%
Chlamydia Screening in Women (CHL)						
CHL: Ages 21-24 Years	NA	NA	NA	25.00%	25.00%	25.00%
CHL: Total Rate	NA	NA	NA	25.00%	25.00%	25.00%
Respiratory Conditions						
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)						
SPR: Rate	NA	27.36%	19.35%	23.91%	23.54%	24.16%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
PCE: Systemic Corticosteroid	74.29%	78.63%	67.80%	77.45%	74.54%	76.50%
PCE: Bronchodilator	85.71%	92.46%	89.78%	87.04%	88.75%	89.08%
Asthma Medication Ratio (AMR)						
AMR: 19-50 years	NA	58.70%	NA	60.79%	59.75%	59.70%

CHC MCO HEDIS Measure	ACP CHC	KF CHC	PAHW	UPMC CHC	PA DHS Mean	Weighted Average
AMR: 51-64 years	NA	49.82%	46.34%	64.20%	53.45%	53.50%
AMR: Total Rate	NA	52.59%	50.93%	62.55%	55.36%	55.87%
Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)						
CBP: Total Rate	67.40%	41.85%	46.96%	70.32%	56.63%	57.77%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)						
PBH: Rate	NA	89.04%	NA	95.29%	92.17%	92.40%
Statin Therapy for Patients With Cardiovascular Disease (SPC)						
SPC: Received Statin Therapy - 21-75 years (Male)	NA	88.17%	82.41%	86.17%	85.58%	86.39%
SPC: Received Statin Therapy - 40-75 years (Female)	NA	87.99%	85.45%	80.61%	84.68%	82.99%
SPC: Received Statin Therapy - Total Rate	87.10%	88.07%	83.94%	83.17%	85.57%	84.57%
SPC: Statin Adherence 80% - 21-75 years (Male)	NA	83.71%	70.79%	88.37%	80.96%	85.84%
SPC: Statin Adherence 80% - 40-75 years (Female)	NA	82.88%	75.53%	88.03%	82.15%	85.65%
SPC: Statin Adherence 80% - Total Rate	NA	83.24%	73.22%	88.19%	81.55%	85.73%
Diabetes						
Comprehensive Diabetes Care (CDC)						
CDC: HbA1c Testing	90.27%	82.44%	76.64%	86.37%	83.93%	84.09%
CDC: HbA1c Poor Control (> 9.0%)	40.39%	49.76%	59.37%	35.77%	46.32%	43.73%
CDC: HbA1c Control (< 8.0%)	49.39%	43.90%	34.06%	56.93%	46.07%	49.21%
CDC: Eye Exam	44.77%	49.76%	38.69%	68.61%	50.46%	57.01%
CDC: Blood Pressure Controlled (< 140/90 mm Hg)	61.31%	31.95%	47.20%	64.72%	51.30%	50.94%
Statin Therapy for Patients With Diabetes (SPD)						
SPD: Received Statin Therapy	79.34%	76.45%	74.75%	74.78%	76.33%	75.45%
SPD: Statin Adherence 80%	81.25%	77.97%	75.06%	84.82%	79.78%	81.50%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
AMM: Effective Acute Phase Treatment	63.10%	63.49%	73.51%	71.69%	67.95%	69.00%
AMM: Effective Continuation Phase Treatment	58.33%	52.63%	63.58%	59.13%	58.42%	57.55%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)						
SSD: Rate	88.52%	79.08%	78.04%	82.36%	82.00%	81.40%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)						
SMD: Rate	61.64%	63.50%	60.92%	75.83%	65.47%	68.86%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)						
SMC: Rate	NA	75.00%	NA	77.27%	76.14%	76.61%
Pharmacotherapy for Opioid Use Disorder (POD)						
POD: Ages 16 - 64 years	NA	29.17%	42.11%	50.72%	40.67%	42.78%
POD: Ages 65+ year	NA	NA	NA	44.44%	44.44%	44.44%

CHC MCO HEDIS Measure	ACP CHC	KF CHC	PAHW	UPMC CHC	PA DHS Mean	Weighted Average
POD: Total Rate	NA	28.80%	39.53%	49.80%	39.38%	42.37%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)						
SAA: Rate	81.13%	68.07%	73.33%	84.00%	76.63%	78.96%
Overuse/Appropriateness						
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
AAB: 18 - 64 years	NA	40.53%	39.22%	38.13%	39.29%	39.08%
AAB: 65+ years	NA	50.00%	NA	31.13%	40.57%	37.34%
AAB: Total Rate	NA	42.56%	41.27%	36.30%	40.04%	38.87%
Use of Imaging Studies for Low Back Pain (LBP)						
LBP: Rate	NA	81.33%	71.67%	75.64%	76.21%	77.18%
Use of Opioids at High Dosage (HDO)						
HDO: Rate	12.26%	14.84%	9.75%	9.55%	11.60%	11.05%
Use of Opioids From Multiple Providers (UOP)						
UOP: Multiple Prescribers	14.24%	11.51%	11.04%	16.31%	13.28%	14.58%
UOP: Multiple Pharmacies	0.95%	2.17%	0.66%	1.87%	1.41%	1.84%
UOP: Multiple Prescribers and Multiple Pharmacies	0.00%	0.76%	0.26%	1.08%	0.53%	0.90%
Risk of Continued Opioid Use (COU)						
COU: 18-64 years - ≥ 15 Days covered	8.29%	22.43%	19.96%	14.28%	16.24%	17.55%
COU: 65+ years - ≥ 15 Days covered	12.12%	14.55%	24.47%	20.86%	18.00%	19.61%
COU: Total - ≥ 15 Days covered	8.85%	21.14%	20.66%	16.47%	16.78%	18.08%
COU: 18-64 years - ≥ 31 Days covered	7.25%	17.63%	15.66%	9.33%	12.47%	12.89%
COU: 65+ years - ≥ 31 Days covered	6.06%	10.84%	15.96%	11.92%	11.20%	11.82%
COU: Total - ≥ 31 Days covered	7.08%	16.51%	15.70%	10.19%	12.37%	12.61%
Prevention and Screening						
Care for Older Adults (COA)						
COA: Advance Care Planning	36.02%	34.55%	73.24%	57.42%	50.31%	52.82%
COA: Medication Review	77.54%	87.35%	90.75%	83.45%	84.77%	84.76%
COA: Functional Status Assessment	55.93%	63.99%	79.32%	67.88%	66.78%	67.56%
COA: Pain Assessment	80.51%	88.81%	85.89%	82.00%	84.30%	83.83%
Medication Management						
Transition of Care (TRC)						
TRC: Notification of Inpatient Admission	3.26%	7.63%	7.33%	35.71%	13.48%	27.49%
TRC: Receipt of Discharge Information	8.82%	5.35%	6.57%	32.79%	13.38%	24.15%
TRC: Patient Engagement After Inpatient Discharge	75.29%	80.05%	76.40%	85.91%	79.41%	83.64%
TRC: Medication Reconciliation Post-Discharge	58.82%	66.67%	45.74%	59.08%	57.58%	59.66%
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						

CHC MCO HEDIS Measure	ACP CHC	KF CHC	PAHW	UPMC CHC	PA DHS Mean	Weighted Average
AAP: Ages 20-44 years	94.69%	90.71%	86.56%	92.89%	91.21%	91.47%
AAP: Ages 45-64 years	98.17%	95.87%	93.11%	96.97%	96.03%	96.16%
AAP: Ages 65+ years	97.09%	94.88%	90.09%	96.55%	94.65%	95.65%
AAP: Total Rate	97.24%	94.81%	91.20%	96.24%	94.87%	95.28%
Long-Term Services and Supports[2]						
Comprehensive Assessment and Update (cau)						
CAU: Assessment of Core Elements	89.58%	75.00%	47.92%	69.79%	70.57%	65.61%
CAU: Assessment of Supplemental Elements	89.58%	75.00%	47.92%	69.79%	70.57%	65.61%
Comprehensive Care Plan and Update (cpu)						
CPU: Care Plan with Core Elements Documented	95.83%	88.54%	50.00%	41.67%	69.01%	65.33%
CPU: Care Plan with Supplemental Elements Documented	95.83%	88.54%	42.71%	41.67%	67.19%	62.96%
Reassessment/Care Plan Update After Inpatient Discharge (rac)						
RAC: Reassessment After Inpatient Discharge	38.54%	31.25%	35.42%	30.23%	33.86%	32.45%
RAC: Reassessment and Care Plan Update After Inpatient Discharge	38.54%	28.13%	31.25%	13.95%	27.97%	23.91%
Shared Care Plan with Primary Care Practitioner (scp)						
SCP: Rate	80.43%	60.00%	22.92%	BR	40.84%	34.73%
Utilization and Risk Adjusted Utilization						
Utilization						
Frequency of Selected Procedures (FSP)[1]						
FSP: Bariatric Weight Loss Surgery, 20-44, M	0.19	0.58	0.22	0.54	0.38	
FSP: Bariatric Weight Loss Surgery, 20-44, F	0.24	0.28	0.12	0.14	0.20	
FSP: Bariatric Weight Loss Surgery, 45-64, M	0.00	0.20	0.00	0.04	0.06	
FSP: Bariatric Weight Loss Surgery, 45-64, F	0.00	0.11	0.00	0.15	0.07	
FSP: Hysterectomy, Abdominal, 15-44, F	0.37	0.00	0.33	0.10	0.20	
FSP: Hysterectomy, Abdominal, 45-64, F	0.00	0.25	0.03	0.11	0.10	
FSP: Hysterectomy, Vaginal, 15-44, F	0.00	0.05	0.00	0.16	0.05	
FSP: Hysterectomy, Vaginal, 45-64, F	0.00	0.04	0.03	0.07	0.04	
FSP: Cholecystectomy, Open, 30-64, M	0.00	0.03	0.06	0.08	0.04	
FSP: Cholecystectomy, Open, 15-44, F	0.00	0.00	0.11	0.00	0.03	
FSP: Cholecystectomy, Open, 45-64, F	0.00	0.06	0.03	0.01	0.03	
FSP: Cholecystectomy, Laparoscopic, 30-64, M	0.33	0.19	0.35	0.45	0.33	
FSP: Cholecystectomy, Laparoscopic, 15-44, F	0.37	0.43	0.00	0.82	0.41	
FSP: Cholecystectomy, Laparoscopic, 45-64, F	0.49	0.27	0.44	0.55	0.44	
FSP: Back Surgery, 20-44, M	0.75	0.05	0.00	0.33	0.28	
FSP: Back Surgery, 20-44, F	0.37	0.34	0.00	0.73	0.36	
FSP: Back Surgery, 45-64, M	0.26	0.71	0.36	0.64	0.49	
FSP: Back Surgery, 45-64, F	1.07	0.62	0.56	0.98	0.81	

CHC MCO HEDIS Measure	ACP CHC	KF CHC	PAHW	UPMC CHC	PA DHS Mean	Weighted Average
FSP: Mastectomy, 15-44, F	0.00	0.38	0.22	0.10	0.18	
FSP: Mastectomy, 45-64, F	0.10	0.10	0.06	0.13	0.10	
FSP: Lumpectomy, 15-44, F	0.19	0.14	0.11	0.22	0.17	
FSP: Lumpectomy, 45-64, F	0.29	0.23	0.09	0.25	0.22	
Ambulatory Care: Total (AMBA)[1]						
AMBA: Outpatient Visits	994.62	829.21	741.61	1,080.30	911.44	956.13
AMBA: Emergency Department Visits	91.08	80.08	77.15	74.48	80.70	77.61
Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)[1]						
IPUA: Total Discharges	33.70	39.50	BR	26.32	33.17	
Antibiotic Utilization: Total (ABXA)						
ABXA: Total Antibiotic Scrips	8,330	27,044	11,439	71,546	29,590	
ABXA: Average Scrips PMPY for Antibiotics	1.89	1.29	1.38	2.08	1.66	
ABXA: Total Days Supply for All Antibiotic Scrips	85,984	268,055	109,005	663,919	281,741	
ABXA: Average Days Supply per Antibiotic Scrip	10.32	9.91	9.53	9.28	9.76	
ABXA: Total Number of Scrips for Antibiotics of Concern	3,652	11,990	4,854	33,052	13,387	
ABXA: Average Scrips PMPY for Antibiotics of Concern	0.83	0.57	0.59	0.96	0.74	
ABXA: Percentage of Antibiotics of Concern of All Antibiotic Scrips	43.84%	44.34%	42.43%	46.20%	44.20%	
Risk Adjusted Utilization						
Plan All-Cause Readmissions (PCR)						
PCR: Count of Index Stays (Ages 18-44)	12	502	145	257	229	
PCR: Count of Index Stays (Ages 45-54)	30	784	206	441	365	
PCR: Count of Index Stays (Ages 55-64)	82	1,575	425	961	761	
PCR: Count of Index Stays (Ages Total)	124	2,861	776	1,659	1,355	
PCR: Count of Observed 30-Day Readmissions (Ages 18-44)	2	94	17	32	36	
PCR: Count of Observed 30-Day Readmissions (Ages 45-54)	8	117	52	46	56	
PCR: Count of Observed 30-Day Readmissions (Ages 55-64)	21	235	83	137	119	
PCR: Count of Observed 30-Day Readmissions (Ages Total)	31	446	152	215	211	
PCR: Count of Expected 30-Day Readmissions (Ages 18-44)	1.67	55.57	16.06	29.68	25.75	
PCR: Count of Expected 30-Day Readmissions (Ages 45-54)	4.57	97.31	27.14	55.87	46.22	
PCR: Count of Expected 30-Day Readmissions (Ages 55-64)	13.80	218.99	58.37	134.80	106.49	
PCR: Count of Expected 30-Day Readmissions (Ages Total)	20.03	371.88	101.57	220.36	178.46	
PCR: Observed Readmission Rate (Ages 18-44)	16.67%	18.73%	11.72%	12.45%	14.89%	
PCR: Observed Readmission Rate (Ages 45-54)	26.67%	14.92%	25.24%	10.43%	19.32%	
PCR: Observed Readmission Rate (Ages 55-64)	25.61%	14.92%	19.53%	14.26%	18.58%	
PCR: Observed Readmission Rate (Ages Total)	25.00%	15.59%	19.59%	12.96%	18.29%	
PCR: Expected Readmission Rate (Ages 18-44)	13.88%	11.07%	11.08%	11.55%	11.90%	
PCR: Expected Readmission Rate (Ages 45-54)	15.24%	12.41%	13.18%	12.67%	13.38%	

CHC MCO HEDIS Measure	ACP CHC	KF CHC	PAHW	UPMC CHC	PA DHS Mean	Weighted Average
PCR: Expected Readmission Rate (Ages 55-64)	16.82%	13.90%	13.74%	14.03%	14.62%	
PCR: Expected Readmission Rate (Ages Total)	16.16%	13.00%	13.09%	13.28%	13.88%	
PCR: Observed to Expected Readmission Ratio (Ages Total)	1.55	1.20	1.50	0.98	1.30	

Note: NA (Not Applicable): the rate is not applicable due to small denominator. BR (Biased Result): the MCO reported a biased result.
[1]Reported rate is per 1,000 member-months.
[2]LTSS measures were produced using the HEDIS specifications and were reviewed outside of the NCQA Audit timeline.

In addition to HEDIS, CHC-MCOs are required to calculate PAPMs, which are validated by IPRO on an annual basis.

Results for PAPMs are presented for each CHC-MCO in **Table 8b**, along with the CHC average and CHC weighted average, which takes into account the proportional relevance of each MCO.

Table 8b: CHC-MCO Results for 2021 (MY 2020) PAPMs

CHC MCO PAPM	ACP CHC	KF CHC	PAHW	UPMC CHC	PADHS MEAN	Weighted Average
Antidepressant Medication Management (AMM PAPM)						
AMM Rate: Effective Acute Phase Treatment	33.70%	22.11%	85.45%	77.71%	54.74%	36.60%
Adults' Annual Dental Visit (AADV PAPM)						
AADV Rate: Adult Annual Dental Visit	17.44%	21.97%	12.16%	22.05%	18.41%	17.58%
Long-Term Services and Supports Expansion – Comprehensive Assessment and Update (CAU PAPM)						
Rate 1 – Assessment of Core Elements	51.04%	NA	37.50%	73.96%	54.17%	54.17%
Rate 2 – Assessment of Supplemental Elements	52.08%	NA	36.46%	90.63%	59.72%	59.72%
Long-Term Services and Supports Expansion – Comprehensive Care Plan and Update (CPU PAPM)						
Rate 1 – Care Plan with Core Elements Documented	48.96%	NA	42.71%	30.21%	40.63%	40.63%
Rate 2 – Assessment of Supplemental Elements	48.96%	NA	42.71%	70.83%	54.17%	54.17%
Long-Term Services and Supports Expansion – Shared Care Plan with Primary Care Practitioner (SCP PAPM)						
SCP Rate: Shared Care Plan with Primary Care Practitioner	37.14%	NA	1.47%	BR	19.31%	18.75%
Long-Term Services and Supports Expansion – Reassessment/Care Plan Update After Inpatient Discharge (RAC PAPM)						
Rate 1 – Reassessment After Inpatient Discharge	42.71%	NA	26.04%	65.85%	44.87%	39.91%
Rate 2 – Reassessment and Care Plan Update After Inpatient Discharge	40.63%	NA	20.83%	31.71%	31.06%	30.90%

Note: NA (Not Applicable): the rate is not applicable due to small denominator. BR (Biased Result): the MCO reported a biased rate.

- One CHC-MCO (UPMC) was found to have an issue in its capacity to produce valid measurement for Long-Term Services and Supports – Shared Care Plan with Primary Care Practitioner. The MCO reported a biased rate.

- One CHC-MCO (PAHW) was found to have an issue in its capacity to produce valid measurement for Inpatient Utilization – Total Discharges. The MCO reported a biased rate.

It is recommended that two CHC-MCOs address the above performance measurement issues for subsequent reporting requirements for 2022 (MY 2021).

Section III: Compliance with Medicaid and CHIP Managed Care Regulations

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

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

Evaluation of PH-MCO Compliance

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

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

IPRO reviewed the elements in the SMART Item List and created a crosswalk to pertinent BBA regulations. The SMART Items did not directly address two categories: Cost Sharing and Effectuation of Reversed Resolutions. Cost Sharing is addressed in the HealthChoices Agreement. Effectuation of Reversed Resolutions is evaluated as part of the most recent NCQA Accreditation review under Utilization Management (UM) Standard 8: Policies for Appeals and UM 9: Appropriate Handling of Appeals. A total of 135 unique SMART Items were identified that were relevant to evaluation of PH-MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS. The SMART Items from Review Year (RY) 2020, RY 2019, and RY 2018 provided the information necessary for this assessment.

The crosswalk linked SMART Items to specific provisions of the regulations, where possible. Some items were relevant to more than one provision. The most recently revised CMS protocols included updates to the structure and compliance standards, including which standards are required for compliance review. Under these protocols, there are 11 standards that CMS has designated as required to be subject to compliance review. Several previously required standards have been deemed by CMS as incorporated into the compliance review through interaction with the new required standards, and appear to assess items that are related to

the required standards. The compliance evaluation was conducted on the crosswalked regulations for all 11 required standards and remaining related standards that were previously required and continue to be reviewed.

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO's compliance status with regard to the SMART Items. For example, all provisions relating to availability of services are summarized under Availability of Services §438.206. This grouping process was done by referring to CMS's "Regulations Subject to Compliance Review", where specific Medicaid regulations are noted as required for review and corresponding sections are identified and described for each Subpart, particularly D and E. Comprehensive findings for standards that were reviewed either directly through one of the 11 required standards below or indirectly through interaction with Subparts D and E can be found in each MCO's 2020 External Quality Review Report. Each Item was assigned a value of compliant or not compliant in the Item Log submitted by the OMAP. If an Item was not evaluated for a particular MCO, it was assigned a value of not determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category. If all Items were compliant, the MCO was evaluated as compliant. If some were compliant and some were not compliant, the MCO was evaluated as partially compliant. If all Items were not compliant, the MCO was evaluated as not compliant. For categories where Items were not evaluated, under review, or received an approved waiver for RY 2020, results from reviews conducted within the two prior review years (RY 2019 and RY 2018) were evaluated to determine compliance. If no Items were evaluated for a given category and no other source of information was available to determine compliance over the three-year period, a value of not determined was assigned for that specific category.

Tables 9a and **9b** summarize compliance assessments for state and federal regulations across MCOs. Across MCOs, there were no categories determined to be partially- or non-Compliant, signifying that no SMART Items were assigned a value of non-Compliant by DHS. **There are therefore no recommendations related to compliance with state and federal regulations for any PH-MCO for the current review year.**

Table 9a: PH-MCO Compliance with Subpart D – MCO, PIHP and PAHP Standards Regulations

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

- Each PH-MCO was compliant for all 10 categories of MCO, PIHP and PAHP Standards Regulations: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegations, Practice Guidelines, and Health Information Systems.

Table 9b: PH-MCO Compliance with Subpart E – Quality Measurement and Improvement; External Quality Review Regulations

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

- Each PH-MCO was compliant for the required Quality Assessment and Performance Improvement Program category for RY 2020.

Evaluation of CHIP-MCO Compliance

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

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

The SMART Items provide the information necessary for each CHIP-MCO's review. The SMART Items are a comprehensive set of monitoring items that the DHS CHIP staff reviews on an ongoing basis for each CHIP-MCO. IPRO reviewed the elements in the SMART Item List and created a crosswalk to pertinent BBA regulations. A total of 44 unique SMART Items were identified that were relevant to the evaluation of CHIP-MCO compliance with the BBA regulations. These Items vary in review periodicity from annually, semiannually, quarterly, monthly, or as needed. The SMART Items from Review Year (RY) 2020 provided the information necessary for this assessment.

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

44 Items were directly associated with a regulation subject to compliance review and were evaluated for the MCO in Review Year (RY) 2020. These items fall under Subpart D: MCO, PIHP and PAHP Standards and Subpart E: Quality Measurement and Improvement. The general purpose of the regulations included under Subpart D is to ensure that all services covered under the DHS's CHIP program are available and accessible to MCO enrollees. [42 C.F.R. § 438.206 (a)] The general purpose of the regulations included under Subpart E is to ensure that each contracting MCO implements and maintains a quality assessment and performance improvement program as required by the State. This includes implementing an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees.

Tables 10a and **10b** summarize compliance assessments for state and federal regulations across MCOs. Across MCOs, there were no categories determined to be partially- or non-Compliant, signifying that no SMART Items were assigned a value of non-Compliant by DHS. **There are therefore no recommendations related to compliance with state and federal regulations for any CHIP-MCO for the current review year.**

Table 10a: CHIP-MCO Compliance with Subpart D – MCO, PIHP and PAHP Standards Regulations

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

- Each CHIP-MCO was compliant for all 10 categories of MCO, PIHP and PAHP Standards Regulations: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegations, Practice Guidelines, and Health Information Systems.

[1] Per CMS guidelines and protocols, this regulation is typically referred to as "Grievance and appeals systems". However, to better align with the CHIP reference for 457.1260, it is referred to in this report as "Grievance systems".

Table 10b: CHIP-MCO Compliance with Subpart E – Quality Measurement and Improvement; External Quality Review Regulations

Subpart E: Quality Measurement and Improvement	ABH	CBC	GEI	Highmark HMO	Highmark PPO	HPP	IBC	NEPA	UHC	UPMC	TOTAL CHIP MMC
Quality assessment and performance improvement program	C	C	C	C	C	C	C	C	C	C	C

- Each CHIP-MCO was compliant for the required Quality Assessment and Performance Improvement Program category for RY 2020.

Evaluation of BH-MCO Compliance

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

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of BH-MCOs by OMHSAS monitoring staff within the past three review years (RYs 2020, 2019, 2018). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2020. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year time frame under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year time frame, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's PS&R Agreement is also used. In 2017, Cambria County moved its contract from BHO (then called Value Behavioral Health) to Magellan Behavioral Health of Pennsylvania (MBH). In 2019, Bedford-Somerset moved its contract from PerformCare to CCBH. If a county is contracted with more than one BH-MCO in the review period, compliance findings for that county are not included in the BBA reporting for either BH-MCO for a three-year period.

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2020 and entered into the PEPS Application as of March 2021 for RY 2020. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the Substandards or "Items" for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional reviewer comments. Based on the PEPS Application, a HealthChoices Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS's more rigorous monitoring criteria.

Because OMHSAS's review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The PEPS substandards from RY 2020, RY 2019, and RY 2018 provided the information necessary for the 2020 assessment. Those standards not reviewed through the PEPS system in RY 2020 were evaluated on their performance based on RY 2019 and/or RY 2018 determinations, or other supporting documentation, if necessary. From time to time

standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating three-year schedule for all five BH-MCOs. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year time frame under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

The format chosen here to present findings related to BH-MCO compliance with MMC regulations follows the rubric described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[iii] Under each general section heading are the regulatory categories requiring reporting. Findings for the BH-MCOs are therefore organized under "Standards, including Enrollee Rights and Protections," "Quality Assessment and Performance Improvement (QAPI) Program," and "Grievance System." Note that under the new CMS rubric, some categories now provide for interaction across Subparts. The standards that are subject to EQR review are contained in 42 C.F.R. 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E.

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision ("category") and evaluated the Primary Contractors' and BH-MCOs' compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met, or not met in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HealthChoices Oversight Entity/BH-MCO, it was assigned a value of not determined. Compliance with the BBA provisions was then determined based on the aggregate results across the three-year period of the PEPS Items linked to each provision. If all Items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all Items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as not compliant. If no crosswalked Items were evaluated for a given provision, and no other source of information was available to determine compliance, a value of not applicable (NA) was assigned for that provision. A value of null was assigned to a provision when none of the existing PEPS Substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. **Table 11a, 11b,** and **11c** summarize PIP compliance assessments across MCOs.

Table 11a: BH-MCO Compliance with Standards, including Enrollee Rights and Protections

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

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

- Based on the total BH MMC score, the HealthChoices Behavioral Health program was compliant with 4 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations: Assurances of adequate capacity and services, Confidentiality, Health information systems, and Subcontractual relationships and delegation.
- Based on the total BH MMC score, the HealthChoices Behavioral Health program was partially compliant with 5 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations: Availability of services, Coordination of continuity of care, Coverage and authorization of services, Practice guidelines, and Subcontractual relationships and delegation.
- Individually, BHO was compliant with 5 of the 9 categories and partially compliant with 4 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, CBH was compliant with 4 of the 9 categories and partially compliant with 5 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, CCBH was compliant with 9 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, MBH was compliant with 8 of the 9 categories and partially compliant with 1 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations
- Individually, PerformCare was compliant with 5 of the 9 categories and partially compliant with 4 of the 9 categories for Standards, including Enrollee Rights and Protections Regulations

Table 11b: BH-MCO Compliance with Quality Assessment and Performance Improvement Program

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

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

- Based on the total BH MMC score, the HealthChoices Behavioral Health program was partially compliant with Quality Assessment and Performance Improvement Program

Table 11c: BH-MCO Compliance with Grievance System

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

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

- Based on the total BH MMC score, the HealthChoices Behavioral Health program was partially compliant with Grievance System

Evaluation of CHC-MCO Compliance

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

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

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

The EQRO utilizes the SMART database findings as of the effective review year, per the following: the CHC Agreement, additional monitoring activities outlined by the Department, and the most recent NCQA Accreditation Survey for each CHC-MCO. Historically, regulatory requirements were grouped to corresponding BBA regulation subparts based on the Department's on-site review findings. Beginning in 2021, findings are reported by the EQRO using the SMART database completed by the Department's staff. The SMART items provide the information necessary for this review. The SMART items and their associated review findings for this year, 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 CHC-MCO compliance with the BBA regulations.

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. The crosswalk links SMART items to specific provisions of the regulations, where possible. Items linked to each standard designated in the protocols as subject to compliance review were included either directly through one of the 11 required standards below, as presented in the below table, or indirectly through interaction with Subparts D and E.

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

Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by the Department. If an item was not evaluated for a particular CHC-MCO, it was assigned a value of Not Determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category (as reflected in **Table 12**). If all items were Compliant, the CHC-MCO was evaluated as Compliant (C). If some were Compliant and some were non-Compliant, the CHC-MCO was evaluated as partially-Compliant (P). If all items were non-Compliant, the CHC-MCO was evaluated as non-Compliant (NC). If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined (ND) was assigned for that category.

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

Table 12: CHC-MCO Compliance with Subpart D (MCO, PIHP and PAHP Standards Regulations) and Subpart E (Quality Measurement and Improvement)

	ACP CHC	KF CHC	PAHW	UPMC	TOTAL CHC MMC
Subpart D: MCO, PIHP and PAHP Standards					
Availability of services	C	C	C	C	C
Assurances of adequate capacity and services	ND	ND	ND	ND	ND
Coordination and continuity of care	C	C	C	C	C
Coverage and authorization of services	C	C	C	C	C
Provider selection	C	C	C	C	C
Confidentiality	C	C	C	C	C
Grievance systems	C	C	C	C	C
Subcontractual relationships and delegation	C	C	C	C	C
Practice guidelines	C	C	C	C	C
Health information systems	C	C	C	C	C
Subpart E: Quality Measurement and Improvement					
Quality assessment and performance improvement program	C	C	C	C	C

- Overall, the CHC-MCOs were found to be compliant across all applicable items directly associated with CFR Categories for Subparts D and E that were subject to review in RY 2020. Additionally, the CHC-MCOs were 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 CHC-MCOs.

Section IV: 2020 Opportunities for Improvement – MCO Response

To achieve full compliance with federal regulations, MCOs are requested to respond to each noted opportunity for improvement from the prior year's reports. For this year's report, the PH-MCOs, BH-MCOs, and CHIP-MCOs had previously identified opportunities for improvement and were requested to respond to the noted opportunities for improvement from the prior year's reports. The general purpose of this section of the report was to document the degree to which each MCO had addressed the opportunities for improvement made by IPRO in the 2020 EQR Technical Reports, which were distributed in April 2021. The 2021 EQR Technical Report is the 14th to include descriptions of current and proposed interventions considered by each MCO as applicable that address the prior year recommendations.

The PH-MCOs, BH-MCOs, CHIP-MCOs, and CHC-MCOs were required to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses were reported consistently across the Pennsylvania MCOs. Generally, the activities followed a longitudinal format and were designed to capture information related to:

- Follow-up actions that the MCOs had taken through June 30, 2021 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

PH-MCOs and BH-MCOs were also required to prepare a Root Cause Analysis and Action Plan for select performance measures noted as opportunities for improvement in the prior year's EQR Technical Report. For 2020, PH-MCOs were required to address those measures on the 2020 Pay for Performance (P4P) Measure Matrix receiving either D or F ratings, while BH-MCOs were required to address any FUH All-Ages rates that fell below the HEDIS (MY 2020) 75 percentile. These MCOs were required to submit the following for each underperforming measure:

- A goal statement,
- Root cause analysis and analysis findings,
- Action plan to address findings,
- Implementation dates, and
- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

Individual current and proposed interventions and applicable Root Cause Analysis and Action Plan for each PH-MCO, BH-MCO, and CHIP-MCOs are detailed in their respective annual technical reports. Corrective action plans that were in place at the OMHSAS level were also forwarded to IPRO to inform the BH-MCO 2022 annual technical reports.

Section V: 2021 Strengths and Opportunities for Improvement and EQR Recommendations

Overall Strengths

- All PH-MCOs were compliant on all eleven State and Federal Regulations standards.
- All PH-MCOs successfully completed NCQA HEDIS Compliance Audits in 2021, and all PH-MCOs successfully calculated and completed validation of all PAPMs.
- All CHIP-MCOs successfully completed NCQA HEDIS Compliance Audits in 2021, and all CHIP-MCOs successfully calculated and completed validation of all PAPMs.
- All CHIP-MCOs were compliant on all eleven State and Federal Regulations standards.
- All five BH-MCOs successfully submitted, for the new PIP, proposals in 2020 for implementation in 2021.
- All five BH-MCOs successfully calculated and completed validation of Performance Measures related to Follow-up After Hospitalization for Mental Illness as well as Readmission Within 30 Days of Inpatient Psychiatric Discharge.
- All BH-MCOs were compliant with Assurances of adequate capacity and services, Confidentiality, Health information systems, and Subcontractual relationships and delegation.
- All PH-MCOs and BH-MCOs provided responses to the Opportunities for Improvements issued in the 2019 annual technical reports.
- All CHC-MCOs had compliance determinations for elements of Project Topic and Rationale, Methodology, Barrier Analysis, and Robust Interventions that were sufficiently met for both PIP topics. For each CHC-MCOs' two PIPs, all scores based on the element determinations exceeded ≥ 85%.
- All CHC-MCOs completed NCQA HEDIS Compliance Audits in 2021 and had their Adult Medicaid CAHPS HP Survey sampling frames validated.
- All CHC-MCOs were 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.

Overall Opportunities

- None of the BH-MCOs met the Quality Compass 75th percentile for the All-Ages/Overall (6+) HEDIS 7-Day Follow-up After Hospitalization for Mental Illness measure. None of the five BH-MCOs met the Quality Compass 75th percentile for the All-Ages/Overall (6+) HEDIS 30-Day FUH measure.
- None of the BH-MCOs achieved the OMHSAS goal of 10% or less for the Readmission Within 30 Days of Inpatient Psychiatric Discharge measure.
- All BH-MCOs were only partially compliant with 5 of the 9 categories of Standards, including Enrollee Rights and Protections
- All BH-MCOs were only partially compliant with Grievance System
- Two CHC-MCOs were found to have an issue with performance measurement: one CHC-MCO was found to have an issue in its capacity to produce valid measurement for Long-Term Services and Supports, Shared Care Plan with Primary Care Practitioner, and the CHC-MCO reported a biased rate; another CHC-MCO was found to have an issue in its capacity to produce valid measurement for Inpatient Utilization – Total Discharges and the CHC-MCO also reported a biased rate.
- One parent CHC-MCO (ACP CHC/KF CHC) was found to have an issue with timely reporting per the submission schedule.

Individual MCO strengths and opportunities are detailed in their respective annual technical reports.

Targeted opportunities for improvement were made for PH-MCOs and BH-MCOs regarding select measures via MCO-Specific Matrices or RCAs and QIPs. For PH-MCOs, each P4P Matrix provides a comparative look at selected measures and indicators included in the Quality Performance Measures component of the

HealthChoices MCO Pay for Performance Program. The P4P Matrix indicates when an MCO's performance rates for the P4P measures are notable or whether there is cause for action. Those measures that fall into the D and F graded categories require a root cause analysis and action plan to assist the MCOs with identifying factors contributing to poor performance.

Table 13 displays the P4P measures for each PH-MCO requiring a root cause analysis and action plan.

Table 13: PH-MCO Root Cause Analysis for 2021 (MY 2020) Measure Results

Rating	ABH	ACP	GEI	GH	HPP	KF	UHC	UPMC
D	Lead Screening in Children Prenatal Care in the First Trimester	Controlling High Blood Pressure Prenatal Care in the First Trimester Developmental Screening in the First Three Years of Life[4]	Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[1]	Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[1]		Comprehensive Diabetes Care: HbA1c Poor Control[5] Prenatal Care in the First Trimester	Comprehensive Diabetes Care: HbA1c Poor Control[5] Prenatal Care in the First Trimester Annual Dental Visit (Ages 2—20 years)[3]	
F	Annual Dental Visit (Ages 2 – 20 years)[3] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[1]	Plan All-Cause Readmissions[2]	Annual Dental Visit (Ages 2 – 20 years)[3]		Comprehensive Diabetes Care: HbA1c Poor Control[5] Annual Dental Visit (Ages 2—20 years)[3] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[1] Developmental Screening in the First Three Years of Life[4] Plan All-Cause Readmissions[2]	Controlling High Blood Pressure Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[1] Developmental Screening in the First Three Years of Life[4]	Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[1] Plan All-Cause Readmissions[2]	Postpartum Care

[1] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaces Well-Child Visits in the First 15 Months of Life, 6 or more.
[2] Plan All Cause Readmissions was added as a P4P measure in 2021 (MY 2020). Lower rates indicate better performance.
[3] Annual Dental Visit (Ages 2 – 20 years) was added as a P4P measure in 2021 (MY 2020).
[4] Developmental Screening in the First Three Years of Life was added as a P4P measure in 2021 (MY 2020).
[5] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.

For the Behavioral Health program, there was another programmatic change in 2018 in the requirements for doing root cause analyses and corresponding action plans. The HEDIS FUH 7-day and 30-day measures for the 6-64 years age group were replaced with the HEDIS Overall (Ages 6+) measures for 7-day and 30-day follow-up. To incentivize improvements in its PA PMs, OMHSAS launched in 2020 a P4P program for HEDIS FUH All Ages and for REA that determined payments based on performance with respect to certain benchmarks and to improvement over prior year. These changes reflect the Commonwealth's increased focus on the aging population. A root cause analysis (RCA) and "quality improvement plan" (QIP) was required for any indicator rate that fell below the NCQA Quality Compass 75th percentile for each indicator. As discussed above, all five BH-MCOs produced HEDIS FUH 7- and 30-day rates that fell below the HEDIS Quality Compass 75th percentile. As a result, all five BH-MCOs submitted RCAs and QIPs for MY 2022. This RCA and QIP planning continued a proactive approach that centered on performance goals for CY 2022 calculated in relation to validated MY 2020 results.

Assessment of Quality, Timeliness, and Access

Responsibility for quality, timeliness, and access to health care services and supports is distributed among providers, payers, and oversight entities. Assessment of the healthcare quality, timeliness, and access of a HealthChoices BH-MCO and its network must therefore include within its scope the coordination among these entities around their shared HealthChoices members.

PH-MCOs

Table 14 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2021 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures and CAHPS Survey, and Compliance with Medicaid and CHIP Managed Care Regulations.

Table 14: PH-MCO 2021 EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Aetna Better Health (ABH)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	Regarding barrier analysis for this PIP, it was recommended that the MCO consider using appropriate root-cause analyses to identify barriers, as the methods reported in the interim report were found to be incongruous with the barriers identified.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It is strongly recommended that ABH consider claims analysis with medical record review validation if not done initially.	Quality
	It is also recommended that ABH use formal root cause analysis (e.g., the 5 Why's) to further develop and identify the root cause of their barriers.	Quality
	Regarding interventions for the interim submission, it was recommended that the MCO indicate that newsletters sent as part of an intervention were distributed annually.	Timeliness
	As part of the overall discussion section of the PIP, it was recommended that the MCO delve deeper into root causes of under-performing interventions or stagnant rates	Quality

Performance Measures and CAHPS Survey		
Ambulatory Health Services	It is recommended that ABH improve access for their members to preventive ambulatory health services. The measure Adults' Access to Preventive/Ambulatory Health Services for ages 20-44 years old, 45-64 years old, and 65 years and older were opportunities for improvement in 2020 and again in 2021.	Access
Childhood Immunizations	It is recommended that the MCO improve childhood immunizations, as Childhood Immunization Status (Combinations 2 and 3) were opportunities in 2020 and again in 2021. Both reported rates that were lower in 2021 than in 2020.	Access, Timeliness
Follow-Up Care for ADHD	It is recommended that ABH improve follow-up care for children prescribed ADHD medication. The plan reported lower rates in 2021 for the following measures: Improve Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase and Continuation Phase, and Improve Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase and Continuation Phase. These measures were opportunities in 2020 and were again identified as opportunities in 2021.	Timeliness
Annual Dental Visits	It is recommended that the MCO focus on improving frequency of annual dental visits for their members. Annual Dental Visits, Annual Dental Visits for Members with Developmental Disabilities, and Adult Annual Dental Visit ≥ 21 Years were all opportunities in 2020 and again 2021. In addition, all measures saw decreased rates in 2021.	Access
Women's Health Services	It is recommended that ABH improve women's health screening services, as the following measures were opportunities in 2020 and again in 2021: Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in Women.	Access, Timeliness
Opioid Use	It is recommended that the MCO work to improve measures associated with opioid use in its member population. Both Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine) and Opioids From Multiple Providers (4 or more prescribers) were opportunities in 2020 and again in 2021.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
AmeriHealth Caritas Pennsylvania (ACP)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It is recommended that the plan expand upon this section in terms of project dates to better contextualize with the PIP.	Quality
	It is recommended that statistics that the plan included regarding African American pregnant people with addiction, per PA DOH data, be reviewed and confirmed to support the plan's conclusion regarding their member data.	Quality
	It is noted that target rates were not increased or reassessed based on meeting or exceeding goals set out at the proposal of the project. It was recommended that comments are included in the report to explain the rationale for not updating the targets.	Quality
	When reviewing methodology and selected performance indicator measurement over time, it is recommended that ACP include an explanation of how the data collection and numerators and denominators of these indicators	Quality

	and intervention tracking measures (ITMs) were determined. This is particularly salient considering the merging of the ACN and ACP companies into one entity in 2021.	
	It is recommended that rationale for why some of the barriers to the interventions were not adjusted or modified earlier than 10/2021, such as outreach interventions done via mailings or telehealth methods.	Quality
	Given reported improvement across many indicators, it is recommended that the MCO revisit goals and revise where possible to account for this improvement.	Quality
	In the plan's discussion of interim results, it is recommended that a statement be included in the Interim report whether there were threats to validity or limitations found. If there were none, a statement should be added to this effect.	Access, Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	As noted above for the MCO's Opioid PIP, reviewers recommended that goals that have been met or exceeded their target rates be increased with rationale based on the current year's calculations and results.	Quality
	Regarding interventions, it is recommended that the MCO add consistent and clear numerator and denominator definitions.	Quality
	It was noted that target rates were not increased or reassessed based on meeting or exceeding goals set out at the proposal of the project. It is recommended that the MCO revised target goals whose reported rates have surpassed them.	Quality
	In the MCO's Discussion section, it is recommended that a statement be included in the Interim report regarding whether there were threats to validity or limitations found. If there were none, a statement should be added to that effect.	Access, Quality
Performance Measures and CAHPS Survey		
Weight Assessment and Counseling	It is recommended that ACP improve weight assessment and counseling, particularly for members age 3 to 11 years. The measure Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index: Percentile and Counseling for were opportunities for improvement in 2020 and again in 2021. Both rates also decreased in 2021.	Access
Women's Health Screenings	It is recommended that the MCO improve screening access for their members, particular around women's health. The measure Chlamydia Screening in Women was an opportunity in 2020 for all age cohorts, and was identified as an opportunity again in 2021.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Geisinger Health Plan (GEI)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It is recommended that the MCO review guidance provided during the Proposal period regarding the inclusion of MCO baseline rates in discussion around why this project topic is an area of opportunity for GEI.	Quality
	It is recommended that that amount of improvement sought for this project, along with the interventions that will be used to achieve this improvement, be stated clearly in the report.	Quality

	It was recommended that GEI utilize formal root cause analyses such as the 5 Whys and other modalities to determine underlying causes of their barriers.	Quality
	It was recommended that the MCO implement the specific guidance provided regarding their selected ITMs, including adding definitions for all and ensuring there is an ITM for each intervention that was developed.	Quality
	Regarding the data provided in the Results section, it was recommended that an explanation be included as to why the baseline data for Indicator 6 could not be validated.	Quality
	It was recommended that GEI complete the Discussion section of the Interim Report in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It is strongly recommended that GEI use the guidance provided during Proposal review in conjunction with the example AIMs statement provided within the PIP template to completely revise the AIMs and Objectives section.	Quality
	Regarding target rates, it is recommended that the MCO calculate out all target rates based upon the baseline period data provided.	Quality
	It is recommended that the project timeline be updated to reflect specific start dates for better tracking throughout the lifetime of the PIP.	Timeliness
	It is recommended that the MCO consider determining if medication adherence is a true barrier in this population and designating the identified ITM as a separate and independent intervention.	Quality
	It is recommended that GEI complete the Discussion section of the Interim Report in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.	Quality
Performance Measures and CAHPS Survey		
Annual Dental Visits	It is recommended that GEI improve access to annual dental visits for its members. The measures Annual Dental Visit (Age 2–20 years) and Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years) were both opportunities in 2020 and again in 2021. Both measures have reported rates that decreased in 2021.	Access
Women's Health Screenings	It is recommended that the MCO improve screening access for their members, particular around women's health. The measure Chlamydia Screening in Women was an opportunity in 2020 for all age cohorts, and was identified as an opportunity again in 2021.	Access
Access to Contraceptive Care	It is recommended that GEI improve access to contraceptive care for postpartum women. The Contraceptive Care for Postpartum Women: LARC - 60 days measure for ages 15 to 20 and 21 to 44 decreased in 2021, and were opportunities in 2020 and 2021.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

Gateway Health (GH)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It is recommended that rates of OUD be split out by race to showcase member data that specifically supports the Project Topic.	Quality
	It was recommended that the MCO explore further development of barriers, namely determining root causes, rather than reporting and outcome as a barrier. Examples were provided to the MCO.	Quality
	It is recommended that all ITMs with denominator of '0' be revised to be 'N/A'.	Quality
	It is recommended that GH include examples, such as ones provided in the report template, to identify factors that threaten internal and external validity to the study.	Access
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the MCO include corrected references to HEDIS in the report's Methodology section. They are currently referring to the incorrect baseline period, MY 2020 rather than MY 2019.	Quality
	It was recommended that the MCO revise Indicator 4 to include two denominators, an Initiation and Engagement denominator.	Quality
	It was recommended that the MCO explore further development of barriers, namely determining root causes. Examples were provided to the MCO.	Quality
	It was recommended that GH include examples, such as ones provided in the report template, to identify factors that threaten internal and external validity to the study.	Access
Diabetes Care	It is recommended that GH improve diabetes care, particularly for its members with diagnosed serious mental illness. The measure Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) for members age 18 – 64 years old was an opportunity for improvement in 2020, and was identified again in 2021.	Quality
Heart Failure Admissions	It is recommended that the MCO improve heart failure admissions, particularly for members 65 years and older. Heart Failure Admission Rate increased in 2021 and has been an opportunity for improvement in 2020 and in 2021.	Quality, Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Health Partners Plan (HPP)		
Performance Measures and CAHPS Survey		
Developmental Screening	It is recommended that HPP improve access to developmental screening for the young children in their population. Developmental Screening in the First Three Years of Life was an opportunity in 2020 and again in 2021 for 1 year old, 3 years old, and total rates. These rates also decreased in 2021.	Access
Antipsychotic Medication Monitoring	It is recommended that the MCO improve measures related to monitoring its members on antipsychotic medications. The following measures decreased in 2021 and were opportunities for improvement in 2020 and in 2021:	Quality

	o Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced); o Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1-11 years; 12-17 years; 1-17 years); and o Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 1-11 years; 1-17 years).	
Satisfaction with Health Plan	It is recommended that HPP work to improve member satisfaction related to their health plan. In the 2021 Adult CAHPS survey, rates for the following survey items fell from 2020 and were below the MMC weighted average for 2021: o Satisfaction with Adult's Health Plan (Rating of 8–10); and o Getting Needed Information (Usually or Always).	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Keystone First (KF)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It was recommended that statistics that the plan included regarding African American pregnant people with addiction, per PA DOH data, be reviewed and confirmed to support the plan's conclusion regarding their member data.	Quality
	It was recommended that target rates that met or exceeded goals set at Proposal be reviewed and revised. Otherwise, rationale should be included in the Interim report to explain why updates were not made to these goals.	Quality
	It is recommended that explanation be included in the report as to why some of the barriers and limitations to the interventions were not addressed or modified earlier than October 2021.	Quality
	In the plan's discussion of interim results, it was recommended that a statement be included in the Interim report whether there were threats to validity or limitations found. If there were none, a statement should be added to this effect.	Quality, Timeliness
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the topic informing barriers be consistent with ITM's and address specific barriers. Specific guidance for ITMs in question were provided to the MCO.	Quality
	It was recommended that a new MCO-defined Performance Indicator be considered for this PIP, unless interventions and barrier analysis can be added to support Indicator 4.	Quality
	In the plan's discussion of interim results, it was recommended that a statement be included in the Interim report whether there were threats to validity or limitations found. If there were none, a statement should be added to this effect.	Quality, Timeliness
Performance Measures and CAHPS Survey		
Diabetes Care	It is recommended that KF improve testing and care related to diabetes. The following measures were identified as opportunities in 2020 and again in 2021. They also decreased in 2021.	Quality

	o Hemoglobin A1c (HbA1c) Testing; o Retinal Eye Exam; and o Blood Pressure Controlled <140/90 mm Hg	
Appointments for Care	It is recommended that the plan improve satisfaction with appointments in both its adult and child population. The survey item "Appointment for Routine Care When Needed (Usually or Always)" fell below the MMC weighted average and decreased from 2020 in both the Adult and Child MY 2020 CAHPS survey items.	Timeliness
Compliance with Medicaid and CHIP Managed Care Regulations		
Enrollee Rights	It is recommended that KF work with DHS to fully understand DHS' review findings for any non-Compliant items and plan for correction.	Access, Quality, Timeliness
United Healthcare (UHC)		
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It was recommended that the MCO perform barrier or root cause analysis for ITMs with declining rates and consider revising those associated interventions or creating new interventions that may better impact the associated barrier.	Quality
	It was recommended that the MCO include a note in the Discussion section regarding which ITM outreaches, referrals, and follow-ups have been traditionally done via telehealth or telephonically compared to in-person follow ups. This would give an improved view of how COVID may be impacting these interventions.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was recommended that the MCO include more modification in interventions for stagnating or worsening performance, especially in low provider outreach rates.	Quality
Performance Measures and CAHPS Survey		
Ambulatory Health Services	It is recommended that UHC improve access to ambulatory health services for its members. The measure Adults' Access to Preventive/Ambulatory Health Services was an opportunity in both 2020 and again in 2021 for ages 20-44 and 45-64 years old.	Access
Women's Health	It is recommended the MCO improve access to services related to women's health. The following measures were opportunities for improvement in 2020 and again in 2021: o Breast Cancer Screening; o Cervical Cancer Screening; and o Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15 to 20).	Access
Services for Members on Antipsychotic Medication	It is recommended the MCO improve access to services for its members on antipsychotic medications. The following measures were opportunities for improvement in 2020 and again in 2021: o Adherence to Antipsychotic Medications for Individuals with Schizophrenia;	Access

	o Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12-17 years; 1-17 years); o Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Ages 12-17 years; 1-17 years); and o Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 12-17 years; 1-17 years).	
Satisfaction with Health Plan and Health Care	It is recommended that UHC focus on improving health plan and health care satisfaction for its members who are children. The following items from the MY 2020 CAHPS survey both fell below the MMC weighted average and fell from 2020: o Satisfaction with Child's Health Plan (Rating of 8–10); o Information or Help from Customer Service (Usually or Always); o Satisfaction with Health Care (Rating of 8–10); and o Appointment for Routine Care When Needed (Usually or Always).	Quality, Timeliness
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
UPMC for You (UPMC)		
Performance Improvement Projects (PIPs)		
There are no recommendations related to compliance with PIPs for the MCO for the current review year.		N/A
Performance Measures and CAHPS Survey		
Women's Health Screenings	It is recommended that UPMC improve screening access for women's health issues. Chlamydia Screening in Women (15-20 years old, 21-24 years old, and total) was an opportunity in 2020 and again 2021.	Access
Satisfaction with Health Care	It is recommended that the MCO improve satisfaction with their members health care. In 2021, results from both the Adult and CHIP MY 2020 CAHPS survey showed the following items falling below the MMC weighted average: o Satisfaction with Health Care (Rating of 8–10); and o Appointment for Routine Care When Needed (Usually or Always).	Quality, Timeliness
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

CHIP-MCOs

Table 15 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2021 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures and CAHPS Survey, and Compliance with Medicaid and CHIP Managed Care Regulations.

Table 15: CHIP-MCO 2021 EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Aetna Better Health (ABH)		
Performance Improvement Projects (PIPs)		
Improving Blood Lead Screening Rate in Children 2 Years of Age	Given that intervention 1 was halted at the beginning of 2020, it is recommended that the MCO include discussion regarding why its related tracking measure 1a continued to have reportable data in 2020	Timeliness
	It is recommended that the MCO include discussion surrounding potential causes for the reported increase in lead screening rates, given the decrease in office visits due to COVID-19	Quality
Performance Measures and CAHPS Survey		
Well-Care Visits	It is recommended that the MCO focus efforts on improving access to well-care visits for their members who are children. Well-Child Visits in the First 30 Months of Life (15 months ≥ 6 Visits), as well as Child and Adolescent Well-Care Visits for members age 12—17 years and 18—19 years were identified as opportunities for improvement in 2021.	Access
Weight Management and Counseling	It is recommended that the MCO focus efforts on improving child and adolescent weight management and counseling, as all age cohorts for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile measure were opportunities for improvement in 2021 as well as in 2020.	Quality, Access
Ambulatory Care ED Visits	It is recommended that the MCO focus efforts on improving ambulatory care, specifically the number of outpatient visits, as all age cohorts for the AMBA: Outpatient Visits/1000 MM measure were opportunities for improvement in 2020 and again in 2021.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Capital Blue Cross (CBC)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO focus on active interventions on future PIPs, avoiding interventions such as passive mailings where it is difficult to measure impact.	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO revise final goal statements in their report to align with the end of the PIP, which was 2020. It is recommended that the MCO include numerator and denominator descriptions in their final report for all reported measures.	Quality
	It is recommended that the MCO expand their Discussion section to include denominator reduction for Indicator 1. Additional information regarding the rate reported and finding should also be included.	Quality

	It is recommended that the MCO revise final goal statements in their report to align with the end of the PIP, which was 2020.	Quality
Performance Measures and CAHPS Survey		
Weight Management and Counseling	It is recommended that the MCO focus efforts on improving child and adolescent weight management and counseling, as all age cohorts for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity measure were opportunities for improvement in 2021 as well as in 2020.	Access, Timeliness
Women's Health Screening	It is recommended that the MCO improve access to screenings for their members. Lead Screening in Children (2 years) and Chlamydia Screening in Women (16–20 years and Total) were opportunities in 2020 and have been identified as opportunities again in 2021.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Geisinger Health Plan (GEI)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO include data from each reporting period in its final report, including data from Baseline, Interim 2019, Interim 2020, and Final Period 2021.	Quality
	It is recommended that the MCO reassess outcome indicators when results show marked improvement during a PIP.	Quality
	It is recommended that the MCO revisit both the Discussion and Next Steps sections of their final report, including discussion of results, especially any impacts on indicator and intervention tracking that may have occurred due to the ongoing COVID-19 pandemic.	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO include data from each reporting period in its final report, including data from Baseline, Interim 2019, Interim 2020, and Final Period 2021.	Quality
	It is recommended that the MCO include final goal statements in their PIP that reflect the timeline of the project.	Quality
	It is recommended that the MCO include additional information regarding how the intervention for the barrier "Members being screened but not tested" was implemented and tracked throughout the PIP.	Quality
	It is recommended that the MCO revisit both the Discussion and Next Steps sections of their final report, including discussion of results, especially any impacts on indicator and intervention tracking that may have occurred due to the ongoing COVID-19 pandemic.	Quality
Performance Measures and CAHPS Survey		
Developmental Screening	It is recommended that the MCO improve access to developmental screenings for their members. Developmental Screening in the First Three Years of Life (Total and 3 years old) was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Access

Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Highmark HMO (HMO)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO confirm the data and correct the numerators and denominators as applicable for the developmental screening indicator and all indicators across MYs.	Quality
	It is recommended that the MCO update the abstract to acknowledge the change in the developmental screening indicator to only include the CPT code 96110.	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO confirm the data and correct the numerators and denominators as applicable for all indicators across MYs.	Quality
Annual Dental Visits	It is recommended that the MCO improve frequency of annual dental cleanings for their members. Annual Dental Visits (2–3 years) was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Access
Ambulatory Care Outpatient Visits	It is recommended that the MCO improve outpatient visits related to ambulatory care for their population. Ambulatory Care: Outpatient Visits for member <1 year old was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Health Partners Plan (HPP)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO include a discussion of how developmental screening rates may have increased in the context of the pandemic and fewer in-office visits.	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO examine the reported denominator for Indicator 1 to confirm the data they are reporting is a true reduction in population, and to provide additional information regarding the rate and finding in a revised final report.	Quality
Performance Measures and CAHPS Survey		
Asthma Emergency Room Visits	It is recommended that the MCO improve frequency of emergency room visits for their members with asthma. Annual Number of Asthma Patients with One or More Asthma–Related Emergency Room Visits (Age 2 – 19 years) was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Quality, Timeliness

Ambulatory Care Outpatient Visits	It is recommended that the MCO improve outpatient visits related to ambulatory care for their population. Ambulatory Care: Outpatient Visits for all age cohorts was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Independence Blue Cross (IBC)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO utilize as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project for the given year.	Quality
	It is recommended that the MCO include numerator and denominator descriptions for all intervention tracking measures.	Quality
	It is recommended that the MCO include confirmation that no additional changes were planned at the conclusion of the PIP, as none were included in their final Discussion and Next Steps sections.	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO utilize as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project for the given year.	Quality
	It is recommended that the MCO include numerator and denominator descriptions for all intervention tracking measures.	Quality
	It is recommended that the MCO include confirmation that no additional changes were planned at the conclusion of the PIP, as none were included in their final Discussion and Next Steps sections.	Quality
Performance Measures and CAHPS Survey		
Weight Assessment and Counseling	It is recommended that the MCO improve counseling and assessment of nutrition and physical activity for its members. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity was an opportunity in 2020 for all age cohorts. In 2021, the 12—17 years old age group and the Total were again identified as opportunities.	Timeliness
Ambulatory Care Outpatient Visits	It is recommended that the MCO improve outpatient visits related to ambulatory care for their population. Ambulatory Care: Outpatient Visits for all age cohorts was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Quality
Healthcare Satisfaction	It is recommended that the MCO work to improve satisfaction with their members' healthcare. The MCO scored below the MMC weighted average for all four CAHPS elements that assess satisfaction with the child's doctor, specialist, health plan, and health care coverage.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

First Priority Health (NEPA)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO confirm the data and correct the numerators and denominators as applicable for the developmental screening indicator and all indicators across MYs.	Quality
	It is recommended that the MCO update the abstract to acknowledge the change in the developmental screening indicator to only include the CPT code 96110	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO confirm the data and correct the numerators and denominators as applicable for all indicators across MYs	Quality
Performance Measures and CAHPS Survey		
Women's Health Screenings	It is recommended that the MCO improve screening access for its members. Chlamydia Screening in Women was an opportunity in 2020 and in 2021 was again identified as an opportunity.	Access
Respiratory Illness Treatment	It is recommended that the MCO improve testing and treatment for respiratory illness in its members. Appropriate Testing for Pharyngitis and Appropriate Treatment for Upper Respiratory Infection were identified as opportunities in 2020 and were again identified in 2021 for total rate and ages 3–17 years.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
Highmark PPO (PPO)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO confirm the data and correct the numerators and denominators as applicable for the developmental screening indicator and all indicators across MYs.	Quality
	It is recommended that the MCO update the abstract to acknowledge the change in the developmental screening indicator to only include the CPT code 96110	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO confirm the data and correct the numerators and denominators as applicable for all indicators across MYs	Quality
Performance Measures and CAHPS Survey		
Women's Health Screenings	It is recommended that the MCO improve screening access for its members. Chlamydia Screening in Women was an opportunity in 2020 and in 2021 was again identified as an opportunity.	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
United Healthcare Community Plan (UHC)		
Performance Improvement Projects (PIPs)		

There are no recommendations related to compliance with PIPs for the MCO for the current review year.		N/A
Performance Measures and CAHPS Survey		
Ambulatory Care Outpatient Visits	It is recommended that the MCO improve outpatient visits related to ambulatory care for their population. Ambulatory Care: Outpatient Visits for all age cohorts was an opportunity in 2020 and has been identified as an opportunity again in 2021	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A
UPMC for Kids (UPMC)		
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO check and confirm all indicator rates reported and use consistent numerators across years.	Quality
Performance Measures and CAHPS Survey		
Annual Dental Visits	It is recommended that the MCO improve frequency of dental visits for their population. Annual Dental Visit (for 11–14 years old and 15–18 years old age cohorts) was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Access, Timeliness
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

BH-MCOs

Table 16 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2021 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures, and Compliance with Medicaid Managed Care Regulations their relevance to the Quality, Timeliness, and Access domains. Since 2020 was the baseline year, and the MCOs met all requirements of the proposal stage, there are no recommendations applicable for this review period.

Table 16: BH-MCO 2021 EQR Recommendations

Measure/Project	IPRO's Recommendation	Domains
Beacon Health Options of Pennsylvania (BHO)		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	No recommendations	Quality, Timeliness, Access

Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with BHO's findings of its RCA and proposed remediations in its QIP, which center on addressing: increasing timely outreach post-discharge, while addressing social determinants of health, and improving communication and coordination among providers and related resources.	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with BHO's findings of its RCA and proposed remediations in its QIP, which center on addressing: increasing timely outreach post-discharge, while addressing social determinants of health, and improving communication and coordination among providers and related resources.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	BHO should continue conduct RCA into the drivers of readmissions among members discharged from an inpatient psychiatric stay. It should leverage the barrier analyses already conducted for its PEDTAR PIP, but also conduct additional RCA for members without AOD diagnoses.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Availability of Services	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Coordination and continuity of care	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Coverage and authorization of services	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Practice Guidelines	BHO was partially compliant with two substandards centered on a defined program of care that incorporates longitudinal disease management. BHO should focus on rationalizing allocation of case management resources which will furthermore strengthen documentation related to the application of medical necessity criteria.	Quality, Timeliness, Access
Grievance and appeal systems	BHO was found not compliant with the substandard that Complaint case files include documentation of any referrals and subsequent corrective action and follow-up related to complaint issues. BHO should ensure that any follow-up and corrective actions are documented in a member's file or appropriately referenced for ready access.	Quality, Timeliness, Access
Community Behavioral Health (CBH)		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	No recommendations	Quality, Timeliness, Access

Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	CBH has been working on RCAs and QIPs related to their FUH rates for a number of years now, and rates continue to fall. CBH's new PIP centering on improving the continuum of SUD care, particularly for Black, non-Hispanic members with disproportionately low treatment initiation and engagement rates, can be expected to help improve FUH rates to the extent there is comorbidity between SUD and mental illness. Still, for MCOs like CBH facing systemic resistance to policy efforts with no clear culprit, logic models of change can be operationalized using tools and techniques, including system dynamics simulation modeling, to help identify potential leverage points for bringing about change at lower cost.	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	CBH has been working on RCAs and QIPs related to their FUH rates for a number of years now, and rates continue to fall. CBH's new PIP centering on improving the continuum of SUD care, particularly for Black, non-Hispanic members with disproportionately low treatment initiation and engagement rates, can be expected to help improve FUH rates to the extent there is comorbidity between SUD and mental illness. Still, for MCOs like CBH facing systemic resistance to policy efforts with no clear culprit, logic models of change can be operationalized using tools and techniques, including system dynamics simulation modeling, to help identify potential leverage points for bringing about change at lower cost.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	CBH should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Availability of Services	CBH was noncompliant with two substandards concerned with monitoring the quality of services received by its members. CBH should conduct a root cause analysis of its member outcome- and network monitoring gaps. CBH's Corrective Action Plan in this area has focused on ensuring: that Grievance related information is reported accurately; that each of its levels of care are monitored and accessed for Consumer Satisfaction; and that Consumer Satisfaction goals are specific and measurable.	Quality, Timeliness, Access
Coordination and continuity of care	CBH was partially compliant with documentation of correct application of medical necessity criteria in care management (CM). IPRO concurs with the recommendations made by OMHSAS: CBH should consider training and/or oversight with feedback of the denial letters, with focus on the clinical rational specific to the individual; and CBH should consider initiating a continuous quality improvement process based on identified goals. Suggested action items include the following: Operationalize each of the "next steps" identified in the ACMR; Prioritize the next steps and establish timeline for implementation.	Quality, Access

Coverage and authorization of services	CBH was partially compliant due in part to with issues with denial letters. IPRO concurs with OMHSAS recommendations from existing correction action plans centering on the implementation of the denial letter template and related standards.	Quality, Access
Practice guidelines	CBH was noncompliant with two substandards concerned with monitoring the quality of services received by its members. CBH should conduct a root cause analysis of its member outcome- and network monitoring gaps. CBH's Corrective Action Plan in this area has focused on ensuring: that Grievance related information is reported accurately; that each of its levels of care are monitored and accessed for Consumer Satisfaction; and that Consumer Satisfaction goals are specific and measurable.	Quality, Timeliness, Access
Provider selection	CBH should ensure that results of provider profiling be incorporated into recredentialing.	Quality
Quality assessment and performance improvement program	CBH was noncompliant with two substandards concerned with monitoring the quality of services received by its members. CBH should conduct a root cause analysis of its member outcome- and network monitoring gaps. CBH's Corrective Action Plan in this area has focused on ensuring: that Grievance related information is reported accurately; that each of its levels of care are monitored and accessed for Consumer Satisfaction; and that Consumer Satisfaction goals are specific and measurable.	Quality, Timeliness, Access
Grievance and appeal systems	CBH was partially compliant with Grievance and appeal systems standard due to deficiencies associated with maintaining effective oversight of the complaint process. IPRO concurs with OMHSAS' finding that CBH Complaint and Grievance Managers must develop a monitoring process that ensures that there is adequate and organized case documentation, including documentation of any CBH-assigned corrective actions carried out by providers.	Quality, Timeliness, Access
Community Care Behavioral Health (CCBH)		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	No recommendations	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness which suggests it should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities, and Centers of Excellence to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that	Timeliness, Access

	ultimately impact quality, timeliness, and access to care, the MCO can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention.	
PA Follow-Up After Hospitalization for Mental Illness rates	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness which suggests it should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities, and Centers of Excellence to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that ultimately impact quality, timeliness, and access to care, the MCP can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention.	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	CCBH continues to make progress on reducing readmissions after hospitalizations for mental illness which suggests it should continue with, and possibly expand, existing efforts in this area. CCBH's success with securing follow-up visits post-discharge for this population—as reflected in its consistently strong performance on the HEDIS Quality Compass FUH percentiles, COVID-19 notwithstanding—is likely helping to reduce avoidable readmissions. In its current PEDTAR PIP, CCBH is planning to leverage its partnership with counties, single county authorities (SCAs), and Centers of Excellence (COE) to improve warm handoffs for initiation and engagement into specialty SUD treatment as well as improve MAT penetration rates, especially for its historically underserved African-American and Hispanic members. If CCBH is able to bring about similar outcome improvements for its members with SUD, while simultaneously addressing deficiencies in its grievance and appeal system that ultimately impact quality, timeliness, and access to care, the MCO can expect to achieve at or above par performance in this important area of treatment (services). The PIP's anti-stigma campaign, combined with provider trainings, will also help improve performance with respect to prevention.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Grievance and appeal systems	CCBH was partially complaint with Grievance and appeal systems standard due to deficiencies associated with maintaining effective oversight of the complaint process. IPRO concurs with OMHSAS' recommendations, which include: ensuring consistent use of templates; reminding investigators and review panel members of the importance of closely reviewing information and evidence; reiterating with provider network the importance of providing information, documentation, and evidence requested by the CCBH Complaint Investigators; and ensuring	Quality, Timeliness, Access

	sufficient documentation of outcomes of follow-up actions. CCBH should also ensure that both the member and the member's representative, if designated, receive a Grievance Acknowledgment Letter and written notice of the Grievance review decision on the correct Appendix H templates.	
Magellan Behavioral Health		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	No recommendations	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide- Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management."	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide- Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management."	Timeliness, Access
Readmission Within 30 Days of Inpatient Psychiatric Discharge	MBH should continue to conduct root cause analyses into the drivers of readmissions among members discharged from an inpatient psychiatric stay. It should leverage the barrier analyses already conducted for its PEDTAR PIP. MBH identified significant opportunities for improvement in several areas, starting with high rates of AMA and AWOL discharges from high levels of SUD inpatient care. The PIP interventions as a set seek to address the entire continuum of care, including prevention and early detection as well a complex chronic disease management of comorbid conditions. MBH's multifaceted approach targeting both member engagement but also provider training and network enhancements places the MCO in a strong position to improve quality, timeliness, and access to care for its members.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Coverage and authorization of services	MBH was partially compliant with a substandard related to the correct use of available denial letter templates. MBH should ensure that it consistently uses the correct applicable template, including the Additional Information Template when needed.	Timeliness, Access
Quality assessment and performance improvement program	MBH was noncompliant with one substandard requiring regular reporting to the Department of Human Services (DHS) on accurate and timely QM data. IPRO concurs with the corrective action plan: The MBH Program Description, Work Plan and Program Evaluation should identify specific due dates for	Quality, Timeliness, Access

	submission to remain consistent with the External Quality Review (EQR) PEPS Matrix that is distributed by OMHSAS annually to the Primary Contractors and BH-MCOs.	
Grievance and appeal systems	MBH was partially compliant with Grievance and appeal systems standard due to deficiencies associated with maintaining effective oversight of the complaint process. IPRO concurs with the findings of the corrective action plan: Decision letters need to be clear and concise by including a summary of the findings from the investigation rather than explaining the entire investigation process. IPRO concurs with the following recommendations: Magellan should develop criteria to determine when an on-site provider review is warranted (e.g., health and safety concerns). It also recommended that Magellan outline criteria to determine when follow-up is needed, and Magellan should develop a process to determine member satisfaction with the Complaint outcome and document where appropriate. MBH was also partially compliant with substandards concerned with the communication of Grievance and Fair Hearing processes, procedures and Member rights. MBH should formalize a process to follow up with members to assess satisfaction with the Grievance process. In addition, MBH should identify criteria related to onsite provider reviews and follow-up actions.	Quality, Timeliness, Access
PerformCare		
Performance Improvement Projects (PIPs)		
Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders	No recommendations	Quality, Timeliness, Access
Performance Measures		
HEDIS Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with PerformCare's findings of its RCA and proposed remediations in its QIP, which center on addressing: expanding Re-Engineered Discharge (RED) with two additional mental health inpatient providers; "develop a joint operating agreement between facilities and mental health outpatient providers to ensure communications between the MH IP facilities, Members and MH OP providers and compliance with new value based purchasing requirements;" and development and dissemination of resources and information related to telehealth and viable alternatives for members. PerformCare also noted a lack of engagement among both providers and members related to getting aftercare. IPRO recommends PerformCare leverage interviews, focus groups, member satisfaction surveys, and similar sources to drill deeper into the causes of this lack of engagement so that it can identify concrete interventions to address it.	Timeliness, Access
PA Follow-Up After Hospitalization for Mental Illness rates	IPRO concurs with PerformCare's findings of its RCA and proposed remediations in its QIP, which center on addressing: expanding Re-Engineered Discharge (RED) with two additional mental health inpatient providers; "develop a joint operating agreement between facilities and mental health outpatient providers to ensure communications between the MH IP facilities, Members and MH OP providers and compliance with new value based purchasing requirements;" and development and dissemination of resources and information related to telehealth and viable alternatives for	Timeliness, Access

	members. PerformCare also noted a lack of engagement among both providers and members related to getting aftercare. IPRO recommends PerformCare leverage interviews, focus groups, member satisfaction surveys, and similar sources to drill deeper into the causes of this lack of engagement so that it can identify concrete interventions to address it.	
Readmission Within 30 Days of Inpatient Psychiatric Discharge	For its SUD PEDTAR PIP, PerformCare identified the subpopulation of members with co-occurring SUD and MH conditions as being at elevated risk for readmission, in part due to missed opportunities for coordinating care. PerformCare also identified a need to increase timely stepped-down care from detox, MAT penetration, as well as treatment retention rates, particularly among African-American members. An underlying barrier to improvement common to many of these areas related to SDoH. PerformCare's interventions will include the development and distribution to network-providers of a "toolbox of resources" centered on facilitating screenings, assessments, and referrals to appropriate levels and modalities of care, including the use of Certified Recovery Specialists (CRS). Guiding this implementation at PerformCare will be a dedicated team of BH specialists and clinicians monitoring provider data and informed by an "SU Evidence-Based Treatment Internal Resource Guide." PerformCare's multi-pronged approach to its PEDTAR PIP, starting with the development of internal data- and EBP-driven teams, places it in a strong position to improving outcomes for its members at risk for or afflicted with SUD. Its PEDTAR PIP may well serve as a model for bringing about similar improvements for its members, more generally.	Timeliness, Access
Compliance with Medicaid Managed Care Regulations		
Availability of services	PerformCare was noncompliant with one of the substandards concerned with denial letters. IPRO concurs with the corrective action plan finding that "PerformCare must institute a process to ensure that all denial letters include a) an individualized clinical rationale; and b) the [medical necessity criteria] MNC that was used to make the determination is accurately identified in the denial letter."	Quality, Access
Coordination and continuity of care	PerformCare was noncompliant with one of the substandards concerned with denial letters. IPRO concurs with the corrective action plan finding that "PerformCare must institute a process to ensure that all denial letters include a) an individualized clinical rationale; and b) the [medical necessity criteria] MNC that was used to make the determination is accurately identified in the denial letter."	Quality, Access
Coverage and authorization of services	For this BBA standard, PerformCare was found noncompliant with two substandards concerned with denial letters. In addition to the above recommendation, IPRO concurs with the corrective plan finding that "PerformCare must ensure the Denial rationale is easy to understand and free of medical jargon. They should ensure the reference to [medical necessity criteria] MNC in the rationale is consistent with the direction in OMHSAS' denial templates."	Quality, Access
Practice guidelines	PerformCare was noncompliant with one of the substandards concerned with denial letters. IPRO concurs with the corrective action plan finding that "PerformCare must institute a process to ensure that all denial letters include a) an individualized clinical rationale; and b) the [medical necessity criteria] MNC that was used to make the determination is accurately identified in the denial letter."	Quality, Access

Grievance and appeal systems	PerformCare was noncompliant with one substandard concerned with denial letters. IPRO concurs with the corrective plan finding that "PerformCare must ensure the Denial rationale is easy to understand and free of medical jargon. They should ensure the reference to [medical necessity criteria] MNC in the rationale is consistent with the direction in OMHSAS' denial templates."	Quality, Access

HealthChoices BH recommendations

As mentioned, there are many factors that influence a payer's performance in the major dimensions of healthcare quality, timeliness, and access, many of which are not directly controllable by the MCO. Specific factors and therefore recommendations apply to individual MCOs. Nevertheless, some factors cut across MCOs to include HealthChoices BH program-level considerations. Due to the BH carve-out within Pennsylvania's HealthChoices program, BH-MCOs and PH-MCOs operate under separate contracts, with BH-MCOs contracting with non-overlapping Primary Contractors. Up through 2020, some counties were still opting out of contracting with MCOs, which meant that PA contracted directly with MCOs in some counties. The continuing devolution of contracting to the Primary Contractors, expected to be completed in 2022, should help to simplify the contracting landscape, at least from the MCO's vantage point, by removing this "State option." These changes will also help to position the HealthChoices BH program for VBP. Nevertheless, coordination of care planning and provisions remains a challenge for the BH-MCOs, perhaps particularly with respect to coordination with the PH side of the HealthChoices program. Restrictions related to protecting confidentiality, especially for members with SUD, continue to present a barrier. Some of these restrictions, including PA's Department of Drug and Alcohol Program (DDAP) regulations, are PA-specific and potentially within scope for the PA Commonwealth to address. At the DHS level, the HealthChoices program should continue to seek ways to collaborate on solutions, including a DHS-hosted filesharing process that was recently put in place to allow BH- and PH-MCOs to share appropriately redacted member-level data files.

Pennsylvania's HealthChoices program should continue to develop incentives through PA PM-specific but also more "interdisciplinary" P4P programs like the PH-MCO and BH-MCO Integrated Care Plan (ICP) Program and the Integrated Community Wellness Clinics (ICWC) program, a CMS Waiver program overseen by OMHSAS. As it does, it should consider ways to continue to build the capacity of MCOs and their networks to calculate quality measures on their own. This will enable plans to effectively monitor their QAPI programs and related initiatives on a more continuous basis which will, in turn, position them to succeed in the VBP environment. Key, for payers, to achieving improved outcomes at lower costs is the ability to collect and analyze timely data to identify areas for improvement as well as reinvestment. Here, DHS should ensure that standards around meaningful use and health information technologies, including health information exchanges (HIEs), are up-to-date and reflected in MMC contracts. Finally, as of MY 2020, EQR validation protocols for assessing network adequacy had not been published by CMS. Since the publication of the *2020 Medicaid and CHIP Managed Care Final Rule*, OMHSAS is actively reviewing its network adequacy monitoring program to ensure all relevant requirements are covered in the annual validation activity going forward. For behavioral health, those requirements include: quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[iv] At the same time, PA should continue to support MMC MCOs through grants, technical assistance, or other means, in achieving these standards. For BH, at least, cooperation between DHS and the counties comprising the BH Primary Contractors will likely continue to be a linchpin in improving the quality, timeliness, and access to care within the HealthChoices program. Counties present natural sites for collaboration across PA departments and scopes which may help drive innovation, as DHS's Centers of Excellence program to combat opioid addiction through its collaboration with DDAP's Single County Authorities is demonstrating.

CHC-MCOs

Table 17 has been provided below which includes all recommendations for quality improvement made by IPRO in each MCO's 2021 EQR Annual Technical Report. This table displays the MCOs' recommendations for Performance Improvement Projects, Performance Measures and CAHPS Survey, and Compliance with Medicaid and CHIP Managed Care Regulations.

Table 17: CHC-MCO 2021 EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
ACP CHC/KF CHC		
Performance Improvement Projects (PIPs)		
July 2021 PIP Submissions for Strengthening Care Coordination and Transition of Care from Nursing Facility to the Community	It is recommended that the MCO improve its capacity to submit PIP reports in accordance with the submission schedule.	Timeliness
Performance Measures and CAHPS Survey		
There were no recommendations related to compliance with Performance Measures and CAHPS for the MCO for the current review year.		
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		
PAHW		
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		
Inpatient Utilization – General Hospital/Acute Care (IPU)	It is recommended that PAHW address the erroneous inclusion of Skilled Nursing Facility (SNF) stays in the IPU measures. PAHW should identify the reasons for inclusion of the SNF stays in MY2020 and if such stays were included in prior years, as well as determine a process flow for ensuring that valid reportable rates can be produced for MY2021.	Access, Timeliness
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		
UPMC		
Performance Improvement Projects (PIPs)		
There are no recommendations related to compliance with PIPs for the MCO for the current review year.		
Long-Term Services and Supports: Shared Care Plan	It is recommended that UPMC address care management systems issues to ensure capacity to share care plans for their population.	Access, Timeliness
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		

Section VI: Adult Community Autism Program (ACAP)

Introduction

The Adult Community Autism Program (ACAP) waiver program is overseen by the Bureau of Supports for Autism and Special Populations (BSASP) within the Office of Developmental Programs and is designed to meet the needs of adults with an autism spectrum disorder. The program is administered under the "Agreement for the Adult Community Autism Program (ACAP)" ("Agreement") with Keystone Autism Services (KAS). KAS provides ambulatory medical services and community and support services to the adults enrolled in the program. As of December 2020, 181 members were enrolled in the program.

Performance Improvement Project

A new PIP topic, "Reducing Social Isolation," was selected in 2018 that focuses on mitigating and overcoming social isolation among ACAP members. A Social Isolation Survey tool was developed based on work by the Patient-Reported Outcomes Measurement Information System (PROMIS®), a Northwestern University project funded by the National Institutes of Health, and by Temple University. The survey tool will be utilized on a quarterly basis to record members' perceptions of social isolation, companionship, and community participation. Baseline data were collected during the fourth quarter of 2018. KAS submitted a proposal entitled "Establishing Socially Valued Roles through Person Centered Planning to Reduce Social Isolation of Adults with Autism," in Spring 2019, which was accepted after a revision. The principal intervention features a person-centered social role valorization (SRV) model that sets goals for attaining socially valued roles (SVR). Intervention tracking measures (ITMs) center on measurement using a Goal Attainment Scale (GAS). Two performance indicators are based on the Social Isolation tool: a Social Isolation (SI) Index score which measures the average social isolation of ACAP members, and the percentage of members reporting feeling socially isolated. The PIP started in June 2019. PIP was scheduled to roll out in a staggered fashion to the entire membership over the course of the PIP.

KAS submitted their first annual PIP report in August 2020 which included reporting on the last 6 months of 2019. KAS noted that some progress had been made with respect to SVR goal attainment rates, as well as to the overall percent of members reporting social isolation (40%, down from 48% at baseline). However, results also showed that the mean SI index score did not improve from baseline (= 19). It was acknowledged that prioritizing participation in Year 1 to individuals with higher social isolation (n= 82 out of 179) may also have slowed progress toward the PIP's overall Year 1 goal for a mean SI score = 18.

IPRO noted some deficiencies in the annual reporting which complicated interpretation of results and next steps. No statistical tests were performed to evaluate significance of any observed differences in group means between those receiving the person-centered SRV intervention and those who had not yet started their participation in PIP. Most notably, threats to internal and external validity were found to be insufficiently addressed. Measurement validity of individual SI Survey items remains a concern as does the measurement of goal attainment of SRV goals, a key ITM. A BSASP audit of individual service plans (ISP) of ACAP members identified as participating in the PIP intervention revealed that in some instances "SRV goals" were being set which appeared to have little to do with socially valued roles. Threats to external validity were also insufficiently addressed related to several potential source of bias, including: selection bias, change in risk factor distributions associated with population turnover, and non-response bias. Non-response bias is particularly important given that the two PIP performance indicators carry denominator exclusion criteria related to completion of the eight SI-specific items. IPRO's review noted that without assessment of the impacts, if any, of these biases on the results, there is no valid basis to determine whether the PIP is making a difference with respect to reducing social isolation among the ACAP members. KAS was asked to address these deficiencies in its mid-year and annual reporting going forward.

2020 coincided with Year 2 of the PIP. Accordingly, the second annual review, completed in 2021, adhered to a formal scoring matrix which includes provisions for requiring a corrective action plan (CAP) if the report scores below 85%. IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (Updated: *Validating Performance Improvement Projects, Final Protocol, Version 2.0, September* 2012) and meets the requirements of the updated final rule on

External Quality Review (EQR) of Medicaid Managed Care Organizations issued on May 6, 2016. IPRO's review of the ACAP PIP evaluates the project against 8 elements:

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

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. IPRO's scoring for each element is based on full, partial, and non-compliance status. At the time each element is reviewed, a finding is given of met, partially met, or not met. Elements receiving a finding of met will receive 100% of the points assigned to the element, partially met elements will receive 50% of the assigned points, and not met elements will receive 0%. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. 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 18** presents the findings of IPRO's review of KAS' ACAP PIP for Year 2:

Table 18: KAS ACAP Reducing Social Isolation PIP Year 2 findings

Element	Score (with weight)
Project Topic and Rationale	Met (5%)
Aim Statement	Met (5%)
Methodology	Partial Met (7.5%)
Barrier Analysis	Partial Met (7.5%)
Robust Interventions	Partial Met (7.5%)
Results Table	Met (5%)
Discussion and Validity of Reported Improvement	Partial Met (10%)
Sustainability	N/A
TOTAL	47.5 (out of 80)
Overall Rating	59% (Not Met)

Although KAS made some improvements to its reporting, including some improvement in response rates, many of the same issues identified in the first year report continued. Overall, the second year report scored 59%, triggering a CAP. This CAP, developed in consultation with IPRO and agreed to by BSASP and KAS, centered on remediations in several key areas:

- Methodology – KAS should formalize a methodological framework for implementing a robust SRV model within the context of person-centered planning, which will include development of standard protocols for defining a socially valued role (SVR) and associated objectives as well as measurement of progress on those objectives and SVR.
- Barrier Analysis and Robust Interventions – Once formalized, the methodological framework should inform evidence-based SRV practices and strategies, and associated trainings, for care planning (including skill-building) and provision.
- Discussion and Validity of Reported Improvement – Remediations for the above deficiencies, including enhancement of ITMs to measure implementation fidelity of the PIP, are expected to also address noted deficiencies in discussion and validity of reported improvements. A Difference-in-Difference (DiD) method was also proposed to control for counterfactuals in measurement of "treatment" (intervention) effect.

KAS noted a general improvement from baseline through Year 2 on SI index scores for all members, particularly for those who received the PIP person-centered planning intervention for at least one quarter. A DiD plot suggested that there was a treatment effect. There may however be characteristics associated with the self-selected treatment cohort which correlate with improvement, and this self-selection bias cannot be more fully tested until all ACAP members participate in the PIP intervention. As of the end of 2020, 97 out 181 members had participated in the PIP.

Given the scope of the CAP, BSASP determined that the ACAP "Reducing Social Isolation" PIP should be extended another year through 2023.

Performance Measures

For MY 2020, BSASP continued to implement five performance measures to monitor KAS' QAPI program with respect to key health outcomes:

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

Annual results were submitted by KAS to BSASP in their annual ACAP BSASP Report. As part of its annual compliance review, BSASP reviewed documentation related to KAS' tracking and reporting of the five performance measures. KAS submitted to BSASP documentation which included a description of changes to the methodology used to measure quality. BSASP also reviewed records along with three reports presented to KAS' QAPI Governing Body: Annual (QAPI) Report, Employee Report, and Incident Management Report. KAS was found compliant with requirements related to QAPI reporting. MY 2020 results are reported in **Table 19**.

Table 19: ACAP Results for 2021 (MY 2020) Performance Measures

Annual Number of Law Enforcement Events	17 events
Psychiatric Emergency Room Care	8 events
Psychiatric Inpatient Hospitalization	3 events
Initial PCP visit within three weeks of enrollment	78% of new enrollees
Annual Dental Exam	74%

KAS Compliance with Medicaid Managed Care Regulations

BSASP monitored compliance for 2020 and provided IPRO with a final monitoring report. Findings were presented under the following categories:

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

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

Monitoring includes administrative review of organizational structure, policies, and procedures, as well as a review of the Services category as captured in a sample of ISPs for participants. Thirty-two ISPs were audited for MY 2020.

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[v] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included updates to the 11 BBA standards which are now required for reporting. The standards that are subject to EQR review are contained in 42 C.F.R. 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. In addition, findings for RY 2020 are presented here under the new rubric of the three "CMS sections": Standards, including Enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up were also produced.

The 11 required standards covering these three sections are comprised of 32 CMS review elements, of which 30 were crosswalked to 52 of the BSASP monitoring categories above. BSASP, separately, made a compliance determination on the CMS review element Performance Measurement (per 42 C.F.R. § 438.330(c)). The

compliance finding for the remaining CMS review element, Performance Improvement Projects (per 42 C.F.R. § 438.330(d)), was based on the Year 2 Annual Report review conducted by IPRO. **Table 20** presents the tally of the 54 compliance reviews across the 11 BBA standards and the resulting compliance status for KAS on each MMC standard:

Table 20: KAS Compliance with MMC standards in RY 2020

MMC Standard	Compliance Status	Met	Partially Met	Not Met
Standards, including enrollee rights and protections				
Assurances of adequate capacity and services (42 C.F.R. § 438.207)	Partially Met	3	0	1
Availability of Services (42 C.F.R § 438.206, 42 C.F.R. § 10(h))	Partially Met	8	0	5
Confidentiality (42 C.F.R. § 438.224)	Met	1	0	0
Coordination and continuity of care (42 C.F.R. § 438.208)	Partially Met	4	2	2
Coverage and authorization of services (42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114)	Met	5	0	0
Health information systems (42 C.F.R. § 438.242)	Partially Met	1	1	0
Practice guidelines (42 C.F.R. § 438.236)	Met	2	0	0
Provider selection (42 C.F.R. § 438.214)	Partially Met	3	2	0
Subcontractual relationships and delegation (42 C.F.R. § 438.230)	Partially Met	0	1	0
Quality assessment and performance improvement (QAPI) program				
Quality assessment and performance improvement program (42 C.F.R. § 438.330)	Partially Met	9	2	1
Grievance system				
Grievance and appeal systems (42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424)	Met	1	0	0

KAS was found fully compliant with three of the nine standards within Standards, including enrollee rights and protections. Of the 41 review areas considered, KAS was partially compliant with Provider Monitoring, Information Systems, and ISP (quality of) and not compliant with Audits of Medical and Service Records and Participant Records (record-keeping). KAS was partially compliant with the remaining six standards within Standards, including enrollee rights and protections.

KAS was found to be partially compliant with Quality assessment and performance improvement program, where it was partially compliant with Provider Monitoring and Performance Measures and not compliant with PIP. KAS was fully compliant with all requirements associated with Grievance system.

Conclusions and Recommendations

Review of the compliance findings across the 54 areas reveals significant opportunities for improvement in the following areas: Audits of Medical and Service Records, Participant Records (record-keeping), ISP (quality of), Information Systems, and Provider Monitoring.

BSASP continues to note deficiencies in KAS' ACAP program related to documenting member records related to service planning and provision of services. In particular, integration of information is not always consistent, with critical information from assessments, particularly those related to risks, not being reflected in ISPs. ISP audit findings were presented covering the following areas: ISP Quality; Goals and Objectives; Functional Behavioral Assessment (FBA), Behavioral Support Plan (BSP), Crisis Intervention Plan (CIP), and Medication Therapeutic Management Plan; and Authorized Services. In 2017, BAS introduced the Periodic Risk Evaluation (PRE) as a required assessment. The purpose of the PRE is to identify risks in order to inform planning, monitoring, tracking, and risk mitigation. In the 2018 monitoring cycle, the PRE Monitoring Checklist was added to the clinical monitoring of the ISPs. In 2018, the ACAP Agreement was amended to remove the requirement that every participant must have a FBA, BSP, and CIP. Consequently, the monitoring for these three areas in 2018 was case-specific and depended on whether an FBA and BSP were required and completed during the review period. Systematic Skill Building (SSB) was added as a service in 2018 as part of the Specialized Skill Development (SSD) service array and was included in the monitoring starting with 2019. Monitoring on the SSB covers three areas: Goals & Objectives, Instructional Strategies, and Goal Attainment Scale (GAS). KAS clinical teams received training on person-centered planning in March 2019. As a result of these changes, a new monitoring process was initiated for MY 2019 and continued in MY 2020. Finally, Implementation of GAS and Skill Building Plans (SBPs), along with more general training and guidance on ISPs, was carried out in the 2020 monitoring cycle, as planned. For 2020, BSASP noted a general decrease in the quality of the audited ISPs when compared with MY 2019, reversing the improvement noted in MY 2019. Some improvements, however, did continue, including in the Functional Information component, which assesses whether the ISP reflects strengths and needs as identified on the Scales of Independent Behavior-Revised (SIBR) assessment. BSASP identified a lack of documentation related to risks and risk mitigation strategies as the primary area of weakness associated with ISPs, although other quality areas such as timely PREs at intake, also worsened from MY 2019.

Staffing at KAS to meet ACAP communications-, service-, and reporting demands continues to be a focal area of monitoring. In the past, staffing shortages have impacted timeliness of services. Although staff shortages continue to present a challenge for KAS, BSASP noted KAS measures, such as staff contingency plans, reflected a concerted by the plan to address this issue, despite the interruptions from the COVID-19 pandemic. BSASP also noted an improvement in the timeliness of service authorizations. These improvements marked a reversal of declining performance. That said, KAS should continue to look for ways to streamline recordkeeping, including linking data sources and systems to more automatically update changes, that will enable KAS, despite continuing staff shortages and turnover, to address the opportunities for improvement noted above. These improvements can also be expected to foster improvements in the Performance Measures and PIP requirements, the other areas where KAS was not compliant.

In general, KAS responded to all recommendations and requests for remediation noted by BAS. All KAS responses to non-compliance were accepted as adequately addressing the issues identified.

IPRO's Assessment of the Pennsylvania Managed Care Quality Strategy

Managed Care Quality Strategy, 2021

Pennsylvania's current Quality Strategy, Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy[1], dated December 2020 was developed with input from stakeholders. The Quality Strategy includes objectives, standards, and goals for the following overarching areas that impact health care services: network adequacy and availability; continuous quality improvement (QI); quality metrics and performance targets; PIPs; external independent reviews; Transitions of Care; health disparities; intermediate sanctions; long-term services and supports (LTSS); and non-duplication of EQR activities.

Goals and Objectives

Pennsylvania's Managed Care goals and objectives align with the mission, vision, and values of DHS. Each Medicaid managed care program has unique specific goals and objectives, but they all relate back to DHS's overarching priorities. These goals are listed in **Table 21**.

Table 21: Pennsylvania's Managed Care Quality Strategy Goals, 2021

Pennsylvania's Managed Care Goals
1. Increase access to healthcare services 2. Improve quality of healthcare services 3. Bend the healthcare cost curve

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

Access to Healthcare Services:

- Monitoring of Provider Network Adequacy.
- Building a Medicaid Program Oversight Portal and CHIP Program Oversight Portal
- Monitoring MCO credentialing
- Implementation of a uniform statewide Preferred Drug List
- Monitoring Compliance with Standards, especially
    1. Access and Operations
    2. Special Needs
    3. Cultural Competency

Quality of Healthcare Services

- Oversight of the MCOs
    1. Monitoring
    2. Sanctions
- Framework for Quality Improvement

[1] https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/Medical%20Assistance%20Quality%20Strategy%20for%20Pennsylvania.pdf

1. Quality Management Program
2. Member Satisfaction
3. Performance Improvement Projects
4. Performance Measures
5. Pay for Performance
6. Health Equity
7. External Quality Review

Bending the Cost Curve

- Value Based Payments
- Efficiency Adjustments
- Health Information Technology

Methodology

For this assessment, IPRO utilized the rubric from the CMS Medicaid and CHIP Managed Care: Quality Strategy Toolkit Summary, June 2021 in reviewing the Pennsylvania Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy dated December 2020.

Observations

Structure of programs for physical health, behavioral health, CHIP and LTSS/HCBS are all addressed in detail including the regional approach, the number, and types of plans. DHS describes its process for seeking input from qualified stakeholders in developing its quality strategy. Stakeholders identified include: Medicaid members, the public, Medicaid Assistance Advisory Committee, County Administrators Advisory Committee, Pennsylvania Mental Health Planning Council, Children's Health Advisory Council, Information Sharing and Advisory Committee, and MCOs.

There is high level discussion of Goals, Monitoring QAPI at the MCO level, Sanctions, and Incentive programs. DHS discusses its public facing MPOP dashboard plans. Cultural Competency and Social Determinants of Health/Health Equity are also discussed at a high level. There is discussion of DHS requirements established for MCO collection of data at the level of race, ethnicity and language and analysis of performance measures at this level.

There is a detailed list of objectives in terms of access and availability of services. However, there is no discussion of the current state of access and availability at the program or plan level, or discussion of actions being undertaken to address any gaps if applicable. There is no discussion of the PA results on any measures in comparison to identified peers or national averages.

There is a section on Performance Improvement Project (PIPs). However, it is very high level and does not provide a description of any interventions it proposes to improve access, quality, or timeliness of care. EQRO validation of PIPs is discussed in detail in Section I of this report.

There is a section on transitions of care. However, this section focuses exclusively on transition of members between MCOs and contains no other discussion of transitions between care settings or levels of care.

There is a list of performance measures in use in the monitoring of quality. However, there is no discussion of results, no identification of any underperformance at the program or MCO level, and no discussion of activities undertaken to address underperformance. EQRO validation of Performance Measures is discussed in detail in Section II of this report.

There is no listing of any current MCO sanctions or discussion of prior sanctions within the past three years and how those are being monitored. If any sanctions or corrective actions plans (CAPS) were instated at either the MCO or aggregate level in the past three years, they should be described in the Quality Strategy, and the causes for those actions should be described as well. Any sanctions or CAPS should be updated based on ongoing monitoring of performance against the goals set out in the sanctions and/or CAPs.

Pennsylvania's quality management plan and execution is robust, particularly with regard to the adoption of CMS core measures and an ambitious program to create quality dashboards through the MPOP project. Initiatives that target health equity, social determinants of health, and health information are all forward-looking and expansive. DHS is using the levers available through pay for performance programs to align quality and efficiency within the delivery systems.

Recommendations

IPRO recommends that the next iteration of the Quality Strategy contain the following additions to align more fully with the CMS standards set forth.

- Goals for quality outcomes as captured in performance measures should have numeric targets either in absolute or rate of improvement expressions.
- Specific discussions of quality metrics in the context of a peer group (similar state programs), national averages and comparison of MCOs should be included.
- The discussion of PIPs could include more information about the experience of the MCOs and the impact the individual projects are having on quality outcomes for the members across the state. It should also include a description of any interventions it proposes to improve access, quality, or timeliness of care.
- Any gaps in access to care should be addressed and plans to close those gaps discussed.
- An updated discussion of its network adequacy monitoring program to ensure quality goals align with all relevant network adequacy requirements

Final Project Reports

Upon request, the following reports can be made available:

1. Individual PH-MCO BBA reports for 2021
2. Individual CHIP-MCO BBA reports for 2021
3. Individual BH-MCO BBA reports for 2020
4. Individual CHC-MCO BBA reports for 2021
5. Follow-up After Hospitalization for Mental Illness External Quality Review Rates Report (BH-MCOs)
6. Readmission Within 30 Days of Inpatient Psychiatric Discharge External Quality Review Rates Report (BH-MCOs)
7. HEDIS MY 2020 Member-Level Data Reports, Data Analysis Trends (PH-MCOs)
8. HEDIS MY 2020 Member-Level Data Reports, Data Findings by Measure (PH-MCOs)
9. HEDIS MY 2020 Member-Level Data Reports, Year-to-Year Data Findings – Southeast Zone/Region (PH-MCOs)
10. HEDIS MY 2020 Member-Level Data Reports, Year-to-Year Data Findings – Southwest Zone/Region (PH-MCOs)
11. HEDIS MY 2020 Member-Level Data Reports, Year-to-Year Data Findings – Lehigh/Capital Zone/Region (PH-MCOs)
12. HEDIS MY 2020 Member-Level Data Reports, Year-to-Year Data Findings – New West Zone/Region (PH-MCOs)
13. Medicaid Managed Care (MMC) Performance Measures, Examination of Year-to-Year Statistical Comparisons for MMC Weighted Averages (PH-MCOs)
14. Medicaid Managed Care Performance Measure Matrices (PH-MCOs)
15. Medicaid Managed Care (MMC) Performance Measures, Examination of Year-to-Year Statistical Comparisons for MMC Weighted Averages (BH-MCOs)
16. 2020 HealthChoices Behavioral Health Balanced Scorecard (BH-MCOs)
17. 2021 PA CHIP CAHPS 5.1 Rate Table and Results by Item
18. 2021 CHIP Report Card

Note: Reports 5 through 8 display data by MMC, BH-MCO, HealthChoices Behavioral Health Contractors (reports 5 and 6 only), County, Region (except for report 7), Gender, Age, Race, and Ethnicity.
Reports 9 through 14 display data by MMC, PH-MCO, Region, Race, and Ethnicity.
Reports 3, 5, 6, 15, and 16 includes results by HealthChoices Behavioral Health Contractors

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

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

[iii] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols October 2019* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[iv] Luke Horner, Jung Kim, Megan Dormond, Kiana Hardy, Jenna Libersky, Debra J. Lipson, Mynti Hossain, and Amanda Lechner (2020). *Behavioral Health Provider Network Adequacy Toolkit*. Baltimore, MD: Division of Managed Care Policy, Center for Medicaid and CHIP Services, CMS, U.S. Department of Health and Human Services.

[v] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.