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University of Pittsburgh Medical Center Health Plan

External Quality Review

Annual Technical Report

April 2024

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

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DEPARTMENT OF HUMAN SERVICES

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I. Executive Summary

Purpose of Report

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

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

To comply with *Title 42 CFR § 438.364 External review results (a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Long-Term Living (OLTL) contracted with IPRO, an EQRO, to conduct the 2023 EQR activities for MCOs contracted to furnish the Community Health Choices (CHC) program. CHC is the mandatory managed care program in PA for adults dually eligible for Medicare and Medicaid, older adults, and adults with physical disabilities, in need of long-term services and supports (LTSS). LTSS help individuals perform daily activities in their home such as bathing, dressing, preparing meals, and administering medications. CHC aims to serve more people in communities, give them the opportunity to work, spend more time with their families, and experience an overall better quality of life. CHC was developed to improve and enhance medical care access and coordination, as well as create a person-centered LTSS system, in which people have a full array of quality services and supports that foster independence, health, and quality of life. During the period under review, report year 2023, Pennsylvania's CHC MCOs included University of Pittsburgh Medical Center Health Plan (UPMC). This report presents results of these EQR activities for UPMC.

Scope of External Quality Review Activities Conducted

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

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

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

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

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

(iv) ***CMS Mandatory Protocol 4:*** **Validation of Network Adequacy –** This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population.

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

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

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

While the *CMS External Quality Review (EQR) Protocols* published in January 2023 stated that an information systems capability assessment (ISCA) is a required component of the mandatory EQR activities. CMS previously clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. Findings from IPRO's review of the MCOs' HEDIS final audit reports (FARs) are in the **Validation of Performance Measures** section of this report.

Conclusions and Recommendations

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

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

II. Validation of Performance Improvement Projects

Objectives

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

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

Title 42 CFR § 438.356(a)(1) and *42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, Pennsylvania contracted with IPRO to validate the PIPs that were underway in 2023.

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

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

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

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

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

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

Performance Improvement Project Topics

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

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

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

Technical Methods of Data Collection and Analysis

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

CMS's *Protocol 1. Validation of Performance Improvement Projects* was used as the framework to assess the quality of each PIP, as well as to score the compliance of each PIP with both federal and state requirements. The MCO is encouraged to continuously assess their rates for performance indicators (PIs) each year and adjust goals accordingly, as goals should be robust, yet attainable.

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1: Element Designation

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

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

Findings

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. As noted in **Table 2** (Scoring Matrix), PIPs are also reviewed for the achievement of sustained improvement, which is assessed for the final year of a PIP.

Table 2: Review Element Scoring Weights (Scoring Matrix)

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

Description of Data Obtained

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

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

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

- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)
- 7-Day Follow Up After a Behavioral Health Discharge: Percent of discharges for which the member received follow-up within seven days of discharge
- Transitional Care Planning/Notification of Discharge: Admissions with a discharge status for whom: a) Transitional Care Planning Activities or b) Education to the member, caregiver, or health system to notify the CHC MCO of discharge within two (2) business days of discharge, began during the hospital stay

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

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

Conclusions and Comparative Findings

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

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

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

PIP activities during the year included updating PIP PI goals, baseline rates, barrier analyses, and development and implementation of both interventions and additional PIs. Baseline rates were recalculated (and integrated into the PIP) with improved access to data. Annual PIP reports on Year 4 implementation, which were subjected to external quality review and scored for reporting the year's PIP compliance determinations, were submitted to IPRO in March 2023. Updates on interventions through the first half of 2023 were submitted to IPRO in July 2023.

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

Strengthening Care Coordination

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

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

Transition of Care from Nursing Facility to the Community

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

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

Table 3: PIP Compliance Assessments

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

PIP: performance improvement project.

III. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

HEDIS MY 2022 measures from the NCQA publication, *HEDIS MY 2022 Volume 2: Technical Specifications*, were validated through a standard HEDIS compliance audit of each MCO. The audit protocol includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of measure rates submitted through the Interactive Data Submission System (IDSS). Final Audit Reports were submitted to NCQA for the MCOs. The EQRO conducts a thorough review and validation of source code, data, and submitted rates. For the measures from the NCQA publication, *HEDIS 2022 Technical Specifications for Long-Term Services and Supports Measures*, rates were not certified by NCQA; data was collected for informational purposes only for the Department's use. The MCO successfully completed the HEDIS MY 2022 audit. The MCO received an Audit Designation of Reportable for all applicable NCQA-certified measures.

Description of Data Obtained

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

Table 4: Performance Measure Groupings

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

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

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

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

PA Performance Measure Selection and Descriptions

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

HEDIS Performance Measure Selection and Descriptions

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

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems Survey

The CAHPS program includes many products designed to capture consumer and patient perspectives on health care quality. Survey sample frame validation is conducted by NCQA-certified auditors for the Adult Medicaid CAHPS. The standardized survey instrument selected for Pennsylvania's Community HealthChoices program was the CAHPS 5.1H Adult Medicaid Health Plan Survey.

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

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

Implementation of PA-Specific Performance Measures

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

Conclusions and Comparative Findings

MCO results are presented in **Table 5** through **Table 20**. For each measure, the denominator, numerator, and MY rates with 95% upper and lower confidence intervals (95% CI) are presented. Confidence intervals are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would fall within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.

Rates for both the MY and the previous year are presented, as available (i.e., MY 2022 and MY 2021). In addition, statistical comparisons are made between the MY 2022 and MY 2021 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the *Z* ratio. A *Z* ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s.". For some measures, a lower rate indicates better performance. In addition to each individual MCO's rate, the CHC-MCO average for MY 2022 and a weighted average are presented. The CHC-MCO mean is a simple average of each MCO's rate whereas the weighted average is an average that considers the proportional relevance of each MCO. The CHC-MCO mean does not include measures with denominators less than 30.

Table 5 to **Table 19** show rates up to one decimal place. Calculations to determine differences between rates are based upon unrounded rates. Due to rounding, differences in rates reported in the narrative may differ from the difference between rates presented in the table. **Table 20** shows rates for the CAHPS Adult survey.

Access to/Availability of Care

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

An opportunity was identified for the MY 2022 Access To/Availability of Care measures:

- The AADV rate, while considered reportable and in line with CHC-MCO mean and weighted average, remains low and demonstrates an opportunity for improvement.

Table 5: Access to/Availability of Care

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 20 to 44 years)	5,176	4,875	94.2%	93.5%	94.8%	94.3%	n.s.	91.8%	92.0%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 45 to 64 years)	16,378	15,992	97.6%	97.4%	97.9%	97.8%	n.s.	96.3%	96.5%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 65 years and older)	16,212	15,712	96.9%	96.7%	97.2%	96.9%	n.s.	95.4%	96.0%
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Total)	37,766	36,579	96.9%	96.7%	97.0%	96.9%	n.s.	95.2%	95.7%
PA EQR	Annual Adult Dental Visit (Age 21 and older)	123,641	26,406	21.4%	21.1%	21.6%	20.1%	+	21.5%	21.5%

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

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

Behavioral Health

Strengths are identified for MY 2022 Behavioral Health of Care performance measure:

- Diabetes Monitoring for People With Diabetes and Schizophrenia - 5.9 percentage points above the weighted average
- The Antidepressant Medication Management - Acute Phase measure rate reflected statistically significant improvement over MY 2021.

One opportunity was identified for MY 2022 Behavioral Health performance measure:

- Pharmacotherapy for Opioid Use Disorder rates decreased notably compared to MY 2021.

Table 6: Behavioral Health

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	1,516	1,267	83.6%	81.7%	85.5%	85.0%	n.s.	76.8%	78.5%
HEDIS	Antidepressant Medication Management - Effective Acute Phase Treatment	1,565	1,207	77.1%	75.0%	79.2%	73.0%	+	75.0%	74.9%
HEDIS	Antidepressant Medication Management - Effective Continuation Phase Treatment	1,565	955	61.0%	58.6%	63.5%	60.4%	n.s.	61.0%	59.7%
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	86	67	77.9%	68.6%	87.3%	75.6%	n.s.	74.4%	75.4%
HEDIS	Diabetes Monitoring for People With Diabetes and Schizophrenia	579	454	78.4%	75.0%	81.8%	76.5%	n.s.	68.9%	72.5%
HEDIS	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1,844	1,578	85.6%	83.9%	87.2%	83.8%	n.s.	84.9%	84.8%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Pharmacotherapy for Opioid Use Disorder (Age 65 years and older)	57	24	42.1%	28.4%	55.8%	59.4%	n.s.	42.1%	42.1%
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 16 to 64 years)	280	107	38.2%	32.3%	44.1%	49.2%	-	33.0%	32.6%
HEDIS	Pharmacotherapy for Opioid Use Disorder (Total)	337	131	38.9%	33.5%	44.2%	50.7%	-	34.3%	34.1%

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

Cardiovascular Conditions

No strengths are identified for MY 2022 Cardiovascular Conditions performance measure.

No opportunities are identified for MY 2022 Cardiovascular Conditions performance measure.

Table 7: Cardiovascular Conditions

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure	411	303	73.7%	69.3%	78.1%	74.9%	n.s.	71.3%	71.0%
HEDIS	Persistence of Beta-Blocker Treatment After a Heart Attack	104	99	95.2%	90.6%	99.8%	93.5%	n.s.	93.3%	93.8%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Males ages 21 to 75 years)	1,187	1,054	88.8%	87.0%	90.6%	86.2%	n.s.	88.6%	88.5%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Females ages 40 to 75 years)	1,171	986	84.2%	82.1%	86.3%	81.1%	n.s.	86.4%	85.8%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	2,358	2,040	86.5%	85.1%	87.9%	83.5%	+	87.4%	87.1%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Males ages 21 to 75 years)	1,054	931	88.3%	86.3%	90.3%	86.3%	n.s.	83.9%	86.2%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Females ages 40 to 75 years)	986	848	86.0%	83.8%	88.2%	87.9%	n.s.	84.8%	84.9%
HEDIS	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	2,040	1,779	87.2%	85.7%	88.7%	87.1%	n.s.	84.4%	85.6%
HEDIS	Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Total)	317	14	4.4%	2.0%	6.8%	2.2%	n.s.	2.7%	2.8%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Total)	317	23	7.3%	4.2%	10.3%	2.4%	+	4.7%	5.0%
HEDIS	Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	317	25	7.9%	4.8%	11.0%	2.4%	+	5.0%	5.6%
HEDIS	Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	317	15	4.7%	2.2%	7.2%	1.8%	+	1.9%	2.6%

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

Care Coordination

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

No opportunities are identified for MY2022 Care Coordination performance measures.

- It should be noted that MY 2022 was the first year for the Advance Care Planning measure as a separate measure, broken off from the Care for Older Adults measure, with some specification changes.

Table 8: Care Coordination

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Advance Care Planning	10,018	3,139	31.3%	30.4%	32.2%	N/A	N/A	29.9%	30.9%
HEDIS	Transitions of Care - Notification of Inpatient Admission (Total)	411	187	45.5%	40.6%	50.4%	51.3%	n.s.	28.7%	37.9%
HEDIS	Transitions of Care - Receipt of Discharge Information (Total)	411	168	40.9%	36.0%	45.8%	45.3%	n.s.	20.7%	28.8%
HEDIS	Transitions of Care - Patient Engagement After Inpatient Discharge (Total)	411	368	89.5%	86.5%	92.6%	89.5%	n.s.	83.8%	86.4%
HEDIS	Transitions of Care - Medication Reconciliation Post-Discharge (Total)	411	314	76.4%	72.2%	80.6%	73.7%	n.s.	64.5%	69.8%

[1]For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s.", "N/A," not applicable as measure specifications changed.
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; 2021 Rate N/A: not applicable, as measure specifications changed.

Diabetes

Strengths are identified for MY 2022 Diabetes of Care performance measure:

- Blood Pressure Control for Patients With Diabetes, a 5.3 percentage points over the weighted average and an improvement from MY 2021.
- Kidney Health Evaluation for Patients With Diabetes (Ages 18 to 64 years) - 3.4 percentage points over the weighted average and improved over MY 2021.
- Statin Therapy for Patients With Diabetes - Statin Adherence 80% - 3.4 percentage points over weighted average and improved over MY 2021.

One opportunity for improvement was identified for MY 2022 Diabetes performance measures:

- Though higher than the weighted average, the Eye Exam for Patients with Diabetes measure rate declined over MY 2021 and represents an opportunity for improvement.

Table 9: Diabetes

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Blood Pressure Control for Patients With Diabetes	411	303	73.7%	69.3%	78.1%	70.3%	n.s.	68.1%	68.4%
HEDIS	Eye Exam for Patients With Diabetes	411	294	71.5%	67.0%	76.0%	74.2%	n.s.	63.1%	65.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	411	260	63.3%	58.5%	68.0%	62.8%	n.s.	61.4%	62.8%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control (>9.0%)	411	104	25.3%	21.0%	29.6%	29.2%	n.s.	29.0%	27.1%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 18 to 64 years)	6,511	2,963	45.5%	44.3%	46.7%	43.5%	+	40.0%	42.1%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 65 to 74 years)	2,779	1,473	53.0%	51.1%	54.9%	49.9%	+	49.3%	52.0%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 75 to 85 years)	748	367	49.1%	45.4%	52.7%	49.2%	n.s.	50.5%	51.4%
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Total)	10,038	4,803	47.9%	46.9%	48.8%	45.7%	+	42.7%	45.1%
HEDIS	Statin Therapy for Patients With Diabetes - Received Statin Therapy	5,639	4,395	77.9%	76.8%	79.0%	77.7%	n.s.	78.5%	78.7%
HEDIS	Statin Therapy for Patients With Diabetes - Statin Adherence 80%	4,395	3,837	87.3%	86.3%	88.3%	85.8%	n.s.	83.5%	83.9%

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

Electronic Clinical Data Systems

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

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

Table 10: Electronic Clinical Data Systems

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Adult Immunization Status - Influenza (Ages 19 to 65 years)	19,719	7,811	39.6%	38.9%	40.3%	42.5%	-	32.8%	30.6%
HEDIS	Adult Immunization Status - Td/Tdap (Ages 19 to 65 years)	19,719	8,962	45.5%	44.8%	46.1%	44.5%	n.s.	33.2%	34.4%
HEDIS	Adult Immunization Status - Zoster (Ages 50 to 65 years)	13,241	2,347	17.7%	17.1%	18.4%	16.0%	+	11.2%	13.5%

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

Long-Term Services and Supports

Strengths were identified for MY 2022 Long-Term Services and Supports performance measure:

- Comprehensive Assessment and Update both the Assessment of Core Elements and Assessment of Supplemental Elements showed a statistically significant improvement from MY 2021 to MY 2022.

- Reassessment/Care Plan Update After Inpatient Discharge both the Reassessment and the Reassessment and Care Plan after Inpatient Discharge showed a statistically significant improvement from MY 2021 to MY 2022.

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

Table 11: Long-Term Services and Supports

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Long-Term Services and Supports Comprehensive Assessment and Update - Assessment of Core Elements	96	93	96.9%	92.9%	100.9%	88.5%	+	92.2%	92.1%
HEDIS	Long-Term Services and Supports Comprehensive Assessment and Update - Assessment of Supplemental Elements	96	93	96.9%	92.9%	100.9%	88.5%	+	91.9%	91.9%
HEDIS	Long-Term Services and Supports Comprehensive Care Plan and Update - Care Plan with Core Elements Documented	96	73	76.0%	67.0%	85.1%	63.7%	n.s.	85.2%	84.6%
HEDIS	Long-Term Services and Supports Comprehensive Care Plan and Update - Assessment of Supplemental Elements	96	73	76.0%	67.0%	85.1%	63.7%	n.s.	85.2%	84.6%
HEDIS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge - Reassessment After Inpatient Discharge	96	53	55.2%	44.7%	65.7%	32.3%	+	46.9%	48.9%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge - Reassessment and Care Plan Update After Inpatient Discharge	96	36	37.5%	27.3%	47.7%	17.7%	+	41.1%	38.9%
HEDIS	Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner	96	62	64.6%	54.5%	74.7%	54.3%	n.s.	67.2%	64.6%

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

Overuse/Appropriateness

Strengths are identified for MY 2022 Overuse/Appropriateness performance measure:

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis Ages 18 to 64 years and Total saw statistically significant improvement in the MY 2022 rates compared to MY 2021.
- Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 65 years and older) showed a statistically significant improvement from MY 2021 to MY 2022.

There are no opportunities for improvement identified for MY 2022 Overuse/Appropriateness of Care performance measure.

Table 12: Overuse/Appropriateness

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18 to 64 years)	218	116	46.8%	39.9%	53.6%	33.1%	+	48.3%	50.8%
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65 years and older)	99	63	36.4%	26.4%	46.3%	23.1%	n.s.	38.2%	37.4%
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	317	179	43.5%	37.9%	49.1%	30.5%	+	44.0%	46.3%
HEDIS	Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 18 to 64 years)	3,025	451	14.9%	13.6%	16.2%	14.0%	n.s.	13.3%	13.5%
HEDIS	Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 65 years and older)	1,528	259	17.0%	15.0%	18.9%	20.1%	-	19.6%	17.8%
HEDIS	Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Total)	4,553	710	15.6%	14.5%	16.7%	15.9%	n.s.	14.6%	14.6%
HEDIS	Risk of Continued Opioid Use - At Least 31 Days of Prescription Opioids in a 62-day Period (Ages 18 to 64 years)	3,025	296	9.8%	8.7%	10.9%	8.6%	n.s.	10.2%	9.9%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Risk of Continued Opioid Use - At Least 31 Days of Prescription Opioids in a 62-day Period (Ages 65 years and older)	1,528	136	8.9%	7.4%	10.4%	10.9%	n.s.	12.8%	10.7%
HEDIS	Risk of Continued Opioid Use - At Least 31 Days of Prescription Opioids in a 62-day Period (Total)	4,553	432	9.5%	8.6%	10.4%	9.3%	n.s.	10.7%	10.1%
HEDIS	Use of Imaging Studies for Low Back Pain (Total)	811	215	73.5%	70.4%	76.6%	76.7%	n.s.	77.2%	77.2%
HEDIS	Use of Opioids at High Dosage	5,706	455	8.0%	7.3%	8.7%	8.8%	n.s.	11.5%	10.0%
HEDIS	Use of Opioids From Multiple Providers - Multiple Pharmacies	7,260	167	2.3%	1.9%	2.7%	2.1%	n.s.	1.4%	1.9%
HEDIS	Use of Opioids From Multiple Providers - Multiple Prescribers	7,260	1,349	18.6%	17.7%	19.5%	17.6%	n.s.	15.9%	17.0%
HEDIS	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	7,260	97	1.3%	1.1%	1.6%	1.1%	n.s.	0.6%	1.1%

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

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

Prevention and Screening

Strengths are identified for MY 2022 Prevention and Screening of Care performance measure:

- Breast Cancer Screening - 3.4 percentage points above the weighted average and showed statistically significant improvement over MY 2021.

There are no opportunities for improvement identified for MY 2022 Prevention and Screening of Care performance measure.

Table 13: Prevention and Screening

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Breast Cancer Screening	10,365	6,788	65.5%	64.6%	66.4%	64.0%	+	58.3%	62.1%
HEDIS	Care for Older Adults - Functional Status Assessment	411	294	71.5%	67.0%	76.0%	72.8%	n.s.	62.2%	67.1%
HEDIS	Care for Older Adults - Medication Review	411	368	89.5%	86.5%	92.6%	86.1%	n.s.	95.9%	93.1%
HEDIS	Care for Older Adults - Pain Assessment	411	349	84.9%	81.3%	88.5%	86.6%	n.s.	88.6%	87.4%
HEDIS	Cervical Cancer Screening	411	216	52.6%	47.6%	57.5%	53.3%	n.s.	49.5%	52.3%
HEDIS	Chlamydia Screening in Women (Ages 21 to 24 years)	73	32	43.8%	31.8%	55.9%	42.4%	n.s.	44.7%	44.5%
HEDIS	Chlamydia Screening in Women (Total)	73	32	43.8%	31.8%	55.9%	42.4%	n.s.	44.7%	44.5%

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

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

Race and Ethnicity

No strengths or opportunities were identified for MY 2022 Race and Ethnicity performance measure.

Table 14: Race and Ethnicity

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure - Ethnicity: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Controlling High Blood Pressure - Ethnicity: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Controlling High Blood Pressure - Ethnicity: Hispanic or Latino (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	70.9%	72.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Hispanic or Latino (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	70.9%	72.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Not Hispanic or Latino (Direct)	397	293	73.8%	69.3%	78.3%	NA	NA	71.1%	70.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Not Hispanic or Latino (Total)	397	293	73.8%	69.3%	78.3%	NA	NA	71.1%	70.8%
HEDIS	Controlling High Blood Pressure - Ethnicity: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	73.3%	68.3%
HEDIS	Controlling High Blood Pressure - Race: American Indian and Alaska Native (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	75.0%	75.0%
HEDIS	Controlling High Blood Pressure - Race: American Indian and Alaska Native (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	75.0%	75.0%
HEDIS	Controlling High Blood Pressure - Race: Asian (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	73.6%	72.9%
HEDIS	Controlling High Blood Pressure - Race: Asian (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	73.6%	72.9%
HEDIS	Controlling High Blood Pressure - Race: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	76.1%	76.8%
HEDIS	Controlling High Blood Pressure - Race: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	76.1%	76.8%
HEDIS	Controlling High Blood Pressure - Race: Black or African American (Direct)	70	42	60.0%	47.8%	72.2%	NA	NA	65.7%	63.4%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Controlling High Blood Pressure - Race: Black or African American (Total)	70	42	60.0%	47.8%	72.2%	NA	NA	65.7%	63.4%
HEDIS	Controlling High Blood Pressure - Race: Native Hawaiian and Other Pacific Islander (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Controlling High Blood Pressure - Race: Native Hawaiian and Other Pacific Islander (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Controlling High Blood Pressure - Race: Some Other Race (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	100.0%	100.0%
HEDIS	Controlling High Blood Pressure - Race: Some Other Race (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	100.0%	100.0%
HEDIS	Controlling High Blood Pressure - Race: Two or More Races (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	65.0%	65.0%
HEDIS	Controlling High Blood Pressure - Race: Two or More Races (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	65.0%	65.0%
HEDIS	Controlling High Blood Pressure - Race: Unknown (Indirect)	N/A	N/A	N/A	N/A	N/A	NA	NA	81.8%	57.8%
HEDIS	Controlling High Blood Pressure - Race: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	81.8%	57.8%
HEDIS	Controlling High Blood Pressure - Race: White (Direct)	312	240	76.9%	72.1%	81.8%	NA	NA	73.7%	75.6%
HEDIS	Controlling High Blood Pressure - Race: White (Total)	312	240	76.9%	72.1%	81.8%	NA	NA	73.7%	75.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Hispanic or Latino (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	53.8%	55.5%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Hispanic or Latino (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	53.8%	55.5%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Not Hispanic or Latino (Direct)	395	253	64.1%	59.2%	68.9%	NA	NA	62.1%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Not Hispanic or Latino (Total)	395	253	64.1%	59.2%	68.9%	NA	NA	62.1%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Ethnicity: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	65.3%	58.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: American Indian and Alaska Native (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	100.0%	100.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: American Indian and Alaska Native (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	100.0%	100.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asian (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	70.6%	71.8%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asian (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	70.6%	71.8%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	55.8%	55.4%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	55.8%	55.4%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Black or African American (Direct)	73	39	53.4%	41.3%	65.5%	NA	NA	58.2%	60.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Black or African American (Total)	73	39	53.4%	41.3%	65.5%	NA	NA	58.2%	60.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Two or More Races (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	76.9%	76.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Two or More Races (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	76.9%	76.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	62.6%	42.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: White (Direct)	294	192	65.3%	59.7%	70.9%	NA	NA	61.3%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%) - Race: White (Total)	294	192	65.3%	59.7%	70.9%	NA	NA	61.3%	64.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	N/A	N/A
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Hispanic or Latino (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	30.2%	29.2%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Hispanic or Latino (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	30.2%	29.2%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Not Hispanic or Latino (Direct)	395	99	25.1%	20.7%	29.5%	NA	NA	29.0%	26.7%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Not Hispanic or Latino (Total)	395	99	25.1%	20.7%	29.5%	NA	NA	29.0%	26.7%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	34.7%	41.1%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: American Indian and Alaska Native (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	0.0%	0.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: American Indian and Alaska Native (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	0.0%	0.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asian (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	16.4%	15.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asian (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	16.4%	15.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asked but No Answer (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	26.0%	25.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Asked but No Answer (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	26.0%	25.6%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Black or African American (Direct)	73	28	38.4%	26.5%	50.2%	NA	NA	34.4%	32.3%

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Black or African American (Total)	73	28	38.4%	26.5%	50.2%	NA	NA	34.4%	32.3%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Two or More Races (Direct)	N/A	N/A	N/A	N/A	N/A	NA	NA	19.2%	19.2%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Two or More Races (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	19.2%	19.2%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: Unknown (Total)	N/A	N/A	N/A	N/A	N/A	NA	NA	29.0%	18.9%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: White (Direct)	294	67	22.8%	17.8%	27.8%	NA	NA	28.9%	25.0%
HEDIS	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: White (Total)	294	67	22.8%	17.8%	27.8%	NA	NA	28.9%	25.0%

[1]Comparison of MY 2022 rates to MY 2021 rates is not applicable due to the new race and ethnicity stratification as of MY 2022. This is indicated by NA in the table.
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: Not Available, denominator is less than 30, related results are filtered.

Respiratory Conditions

Strengths are identified for MY 2022 Respiratory Conditions performance measure:

- Although the rate difference for the Asthma Medication Ratio measure was not statistically significant from MY 2021 to MY 2022, the MY 2022 rate compared to the weighted average showed improvement of 6.3 percentage points for Ages 19 to 50 and 12.8 percentage points for Ages 51 to 64.
- The total rate for the Asthma Medication Ratio did not show statistically significant improvement from MY 2021 to MY 2022, although the MY 2022 rate performed better than the weighted average by 10.5 percentage points.

An opportunity is identified for MY 2022 Respiratory Conditions performance measure:

- Use of Spirometry Testing in the Assessment and Diagnosis of COPD showed a statistically significant decrease when compared to MY 2021, which shows an opportunity for improvement.

Table 15: Respiratory Conditions

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Asthma Medication Ratio (Ages 19 to 50 years)	283	203	71.7%	66.3%	77.2%	71.4%	n.s.	66.2%	65.4%
HEDIS	Asthma Medication Ratio (Ages 51 to 64 years)	331	228	68.9%	63.7%	74.0%	66.5%	n.s.	58.7%	56.1%
HEDIS	Asthma Medication Ratio (Total)	614	431	70.2%	66.5%	73.9%	68.8%	n.s.	61.6%	59.7%
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	1,434	1,278	89.1%	87.5%	90.8%	88.9%	n.s.	90.9%	90.9%
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	1,434	1,133	79.0%	76.9%	81.2%	79.1%	n.s.	77.8%	78.8%
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	1,016	194	19.1%	16.6%	21.6%	24.6%	-	21.3%	19.5%

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

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

Utilization – Ambulatory Care/Inpatient Utilization

Strengths are identified for MY 2022 Utilization – Ambulatory Care/Inpatient Utilization performance measures.

- Ambulatory Care – Emergency Department Visits performed better than all comparison groups including MY 2021, CHC-MCO mean, and the weighted average.
- Inpatient Utilization – General Hospital/Acute Care – Total Inpatient Discharges performed better in MY 2022 compared to MY 2021 and the CHC-MCO mean.

No opportunities are identified for MY 2022 Utilization - Ambulatory Care/Inpatient Utilization performance measures.

Table 16: Utilization – Ambulatory Care/Inpatient Utilization

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2021 Rate	MY 2022 CHC-MCO Mean	MY 2022 Weighted Average
HEDIS	Ambulatory Care - Emergency Dept Visits/1000 Member Years (Total)	492,204	39,678	967.0	991.2	998.6	984.1
HEDIS	Ambulatory Care - Outpatient Visits/1000 Member Years (Total)	492,204	553,405	13,492.09	13,323.5	12,397.0	12,338.3
HEDIS	Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1000 Member Years (Total)[1]	492,204	1,210	295.0	306.7	366.5	365.8

[1]Utilization measures are designed to capture the frequency of certain services provided by the organization. NCQA does not view higher or lower service counts as indicating better or worse performance.

Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable.

Utilization – Ambulatory Care/Inpatient Utilization

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

Table 17: Utilization – Antibiotics for Respiratory Conditions

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate[1]	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Antibiotic Utilization for Respiratory Conditions (Total)	18,361	3,282	17.9%	17.3%	18.4%	N/A	N/A	13.0%

[1]Antibiotic Utilization for Respiratory Conditions is a first-year measure where a prior year comparison is not available, indicated by "N/A".
Denom: denominator; Num: numerator; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Utilization – Ambulatory Care/Inpatient Utilization

No strengths or opportunities are identified for MY 2022 Utilization – Frequency of Selected Procedures (FSP) performance measure.

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

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Back Surgery (Females ages 20 to 44 years)	37,334	16	5.1	4.9	5.4	5.0	+	3.3
HEDIS	Frequency of Selected Procedures - Back Surgery (Females ages 45 to 64 years)	132,784	120	10.8	10.7	11.0	13.1	-	8.2
HEDIS	Frequency of Selected Procedures - Back Surgery (Males ages 20 to 44 years)	32,552	11	4.1	3.8	4.3	1.9	+	3.3
HEDIS	Frequency of Selected Procedures - Back Surgery (Males ages 45 to 64 years)	88,506	69	9.4	9.2	9.6	9.8	-	7.2

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 20 to 44 years)	37,334	18	5.8	5.6	6.0	5.8	n.s.	6.5
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 45 to 64 years)	132,784	42	3.8	3.7	3.9	2.2	+	3.3
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 20 and 44 years)	32,552	7	2.6	2.4	2.8	0.4	+	1.8
HEDIS	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 45 to 64 years)	88,506	9	1.2	1.1	1.3	0.8	+	1.1
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 15 to 44 years)	37,334	24	7.7	7.4	8.0	7.1	+	5.6
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 45 to 64 years)	132,784	59	5.3	5.2	5.5	6.0	-	5.3
HEDIS	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Males ages 30 to 64 years)	113,904	40	4.2	4.1	4.3	4.3	-	3.9
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Females ages 15 to 44 years)	37,334	1	0.3	0.3	0.4	0.0	+	0.5
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Females ages 45 to 64 years)	132,784	6	0.5	0.5	0.6	0.7	-	0.8
HEDIS	Frequency of Selected Procedures - Cholecystectomy Open (Males ages 30 to 64 years)	113,904	3	0.3	0.3	0.4	0.6	-	0.7
HEDIS	Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 15 to 44 years)	37,334	7	2.2	2.1	2.4	1.7	+	1.0

Indicator Source	Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 CHC-MCO Mean
HEDIS	Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 45 to 64 years)	132,784	9	0.8	0.8	0.9	0.7	+	1.2
HEDIS	Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 15 to 44 years)	37,334	6	1.9	1.8	2.1	2.0	-	2.3
HEDIS	Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 45 to 64 years)	132,784	6	0.5	0.5	0.6	0.6	-	0.6
HEDIS	Frequency of Selected Procedures - Lumpectomy (Females ages 15 to 44 years)	37,334	7	2.2	2.1	2.4	2.0	+	2.0
HEDIS	Frequency of Selected Procedures - Lumpectomy (Females ages 45 to 64 years)	132,784	32	2.9	2.8	3.0	3.2	-	3.5
HEDIS	Frequency of Selected Procedures - Mastectomy (Females ages 15 to 44 years)	37,334	8	2.6	2.4	2.7	0.7	+	0.6
HEDIS	Frequency of Selected Procedures - Mastectomy (Females ages 45 to 64 years)	132,784	12	1.1	1.0	1.1	0.5	+	1.2

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

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

Utilization – Plan All-Cause Readmissions (PCR)

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

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

Indicator Source	Indicator Name	UPMC MY 2022	UPMC MY 2021
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Count of Index Stays	412	334
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Count of Index Stays	556	523
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Count of Index Stays	1,198	1,128
HEDIS	Plan All-Cause Readmissions (Ages Total) - Count of Index Stays	2,166	1,985
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Observed 30 - Day Readmission	55	30
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Observed 30 - Day Readmission	62	56
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Observed 30 - Day Readmission	148	125
HEDIS	Plan All-Cause Readmissions (Ages Total) - Observed 30 - Day Readmission	265	211
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Expected 30 - Day Readmission	48	38
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Expected 30 - Day Readmission	67	64
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Expected 30 - Day Readmission	173	155
HEDIS	Plan All-Cause Readmissions (Ages Total) - Expected 30 - Day Readmissions	290	258
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Observed Readmission Rate	13.4%	9.0%
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Observed Readmission Rate	11.2%	10.7%
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Observed Readmission Rate	12.4%	11.1%
HEDIS	Plan All-Cause Readmissions (Ages Total) - Observed Readmission Rate	12.2%	10.6%
HEDIS	Plan All-Cause Readmissions (Ages 18 to 44 years) - Expected Readmission Rate	11.9%	11.7%
HEDIS	Plan All-Cause Readmissions (Ages 45 to 54 years) - Expected Readmission Rate	12.2%	12.3%
HEDIS	Plan All-Cause Readmissions (Ages 55 to 64 years) - Expected Readmission Rate	14.5%	13.8%

Indicator Source	Indicator Name	UPMC MY 2022	UPMC MY 2021
HEDIS	Plan All-Cause Readmissions (Ages Total) - Expected Readmission Rate	13.4%	13.0%
HEDIS	Plan All-Cause Readmissions (Ages Total) – Observed to Expected Readmission Ratio	0.9	0.8

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

CAHPS MY 2022 Adult Survey Results

Table 20 provides the survey results of the CAHPS Adult survey data broken out by three key areas: Rating of Access to Care, Ratings of Health Plans, and Ratings of Personal Doctor. Further stratification is provided for the aligned versus the unaligned populations. The aligned population includes Medicaid-CHC only or CHC and an aligned D-SNP. The unaligned population includes CHC and fee-for-service Medicare or other Medicare Advantage product than an aligned D-SNP. The composite questions target the MCOs' performance strengths as well as opportunities for improvement.

Table 20: CHC-MCO CAHPS MY 2022 Adult Survey Results

CAHPS Measure	UPMC - Aligned	UPMC - Unaligned
Your Health Plan		
Satisfaction with Adult's Health Plan (Rating of 8–10)	90.49%	86.22%
Customer Service (Usually or Always)	93.14%	94.38%
Your Access to Care in Last 12 Months		
Getting Needed Care Composite (Usually or Always)	88.04%	88.31%
Getting Care Quickly Composite (Usually or Always)	87.86%	86.95%
Your Personal Doctor		
Satisfaction with Personal Doctor (Rating of 8-10)	85.68%	85.82%
Doctor Informed/Up to Date on Care (Usually or Always)	86.61%	94.59%
How Well Doctors Communicate Composite (Usually or Always)	95.09%	93.75%
Hard to Find Doctor Who Speaks Your Language (Never or Sometimes)	57.30%	71.94%
Hard to Find Doctor Who Understands Your Culture (Never or Sometimes)	67.14%	71.01%

CAHPS: Consumer Assessment of Healthcare Providers Survey

IV. Review of Compliance with Medicaid Managed Care Regulations

Objectives

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

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

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

Throughout the audit, these areas of compliance are discussed with the MCO and clarifying information is provided, where possible. Discussions that occur are compiled along with the reviewed documentation to provide a final determination of compliance, partial compliance, or non-compliance for each section. If an MCO does not address a compliance issue, the Department would discuss as a next step the option to issue a work plan, a performance improvement plan, or a corrective action plan (CAP). Any of these next steps would be communicated in a formal letter sent by email to the MCO.

Technical Methods of Data Collection and Analysis

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO's compliance status with regard to the SMART items. For example, all provisions relating to availability of services are summarized under *Availability of Services § 438.206*. This grouping process was done by referring to CMS's "Regulations Subject to Compliance Review," where specific Medicaid regulations are noted as required for review and corresponding sections are identified and described for each Subpart, particularly D and E. Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by DHS. If an item was not evaluated for a particular MCO, it was assigned a value of Not Determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART items linked to each provision within a requirement or category. If all items were Compliant, the MCO was evaluated as Compliant. If some were Compliant and some were non-Compliant, the MCO was evaluated as partially Compliant. If all items were non-Compliant, the MCO was evaluated as non-Compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined was assigned for that category.

Categories determined to be partially or non-Compliant are indicated where applicable in the tables below, and the SMART items that were assigned a value of non-Compliant by DHS within those categories are noted. For UPMC, there were no categories determined to be partially or non-Compliant, signifying that no SMART items were assigned a value of non-Compliant by DHS. There are therefore no recommendations related to compliance with structure and operations standards for UPMC for the current measurement year.

In addition to this analysis of DHS's monitoring of MCO compliance with managed care regulations, IPRO reviewed and evaluated the most recent NCQA accreditation report for each MCO. IPRO accessed the NCQA *Health Plan Reports* website[4] to review the *Health Plan Report Cards 2022* for UPMC. For each MCO, star ratings, accreditation status, plan type, and distinctions were displayed. At the MCO-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall.

Format

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the subparts set out in the BBA regulations and described in the CMS EQR Protocol: *Review of Compliance with Medicaid and CHIP Managed Care Regulations*. Under each subpart heading falls the individual regulatory categories appropriate to those headings. Findings will be further discussed relative to applicable subparts as indicated in the updated Protocol, i.e., Subpart D – MCO, PIHP and PAHP Standards and Subpart E – Quality Measurement and Improvement.

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

Description of Data Obtained

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

The crosswalk linked SMART Items to specific provisions of the regulations, where possible. Some items were relevant to more than one provision. The most recently revised CMS protocols included updates to the structure and compliance standards, including which standards are required for compliance review. Under these protocols, there are 14 standards that CMS has designated as required to be subject to compliance review. Several previously required standards have been deemed by CMS as incorporated into the compliance review through interaction with the new required standards and appear to assess items that are related to the required standards. The compliance evaluation was conducted on the crosswalked regulations for all 14 required standards and remaining related standards that were previously required and continue to be reviewed.

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

Table 21 includes all regulations and standards from 2023 and related CFR reference citation.

Table 21: Regulations Directly Crosswalked to SMART

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

Determination of Compliance

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

Each item was assigned a value of compliant or non-compliant in the item log submitted by the Department. If an item was not evaluated for a particular MCO, it was assigned a value of not determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART items linked to each provision within a requirement or category. If all items were compliant, the MCO was evaluated as compliant. If some were compliant and some were non-compliant, the MCO was evaluated as partially compliant. If all items were non-compliant, the MCO was evaluated as non-compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of not determined was assigned for that category.

Categories determined to be partially or non-compliant are indicated where applicable in the tables below, and the SMART items that were assigned a value of non-compliant by the Department within those categories are noted. For UPMC, there were no categories determined to be partially or non-compliant, signifying that no SMART items were assigned a value of non-compliant by the Department.

Conclusions and Comparative Findings

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

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

Summarily, the MCO was found to be compliant across all applicable items directly associated with CFR Categories for Subparts B, C, D, and E that were subject to review in 2023. As the MCO was fully compliant, no recommendations were made.

V. Validation of Network Adequacy

Objectives

Title 42 CFR § 438.68(a) requires states that contract with an MCO to deliver services must develop and enforce network adequacy standards consistent with the CFR. At a minimum, states must develop time and distance standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology (ob/gyn), adult and pediatric BH (for mental health and substance use disorder [SUD]), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support (LTSS), per *Title 42 CFR § 438.68(b)*. Pennsylvania DHS has developed access standards based on the requirements outlined in *Title 42 CFR § 438.68(c)*. These access standards are described in the Community HealthChoices Agreement, Exhibit T.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, Pennsylvania contracted with IPRO to perform the validation of network adequacy for Pennsylvania MCOs. In February 2023, CMS released updates to the EQR protocols, including the newly developed network adequacy validation protocol. The protocol six activities related to planning, analysis, and reporting, as outlined in **Table 23.**

Table 23: Network Adequacy Validation Activities

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

[1] At the time of this report, only activities 1 and 2 were conducted for 2023.

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

Technical Methods of Data Collection and Analysis

IPRO gathered information from Pennsylvania to conduct preliminary network adequacy validation activities using worksheets 4.1, 4.2, and 4.3 of the 2023 CMS EQR protocols. The worksheets identified clear definitions for each network adequacy standard. Future work on Network Adequacy will require identification of indicators and data sources for validation, as well as reviewing information systems, and validating network adequacy.

Description of Data Obtained

Network adequacy standards are quantitative parameters that states establish to set expectations for contracted MCOs' provider networks. Network adequacy indicators are metrics used to measure adherence to network adequacy standards and to determine plan compliance with state network adequacy standards. The Pennsylvania-established access, distance, and time standards are presented by the two Pennsylvania geographical regions: urban and rural. **Table 24** displays the Pennsylvania Community HealthChoices provider network standards that were applicable in 2023.

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

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

Pennsylvania Network Access Standards	Applicable Provider Types
Ensure a choice of one (1) provider who is accepting new patients within 60 minutes (rural) and a second choice within the Community HealthChoices Zone.	Endocrinologist, Hematology/Oncology, Rheumatology, Midwife, certified, Nephrology, Speech Therapy
All Other Provider Types must meet the Participants needs through in-network or out-of-network arrangements. CHC-MCOs should make all reasonable efforts to offer two (2) or more Specialty Providers.	All other specialists and subspecialists not previously identified.
Ensure at least one (1) hospital within 60 minutes (rural) and a second choice within the Community HealthChoices Zone. This travel time is measured via public transportation, where available.	Hospitals
Ensure at least one (1) hospital within 30 minutes (urban) and a second choice within the Community HealthChoices Zone. This travel time is measured via public transportation, where available.	Hospitals
For services where the Participant is traveling to the Provider, the CHC-MCO must ensure a choice of two (2) Providers who are accepting new clients within the travel time limits (thirty (30) minutes Urban). This travel time is measured via public transportation, where available.	LTSS
For services where the Participant is traveling to the Provider, the CHC-MCO must ensure a choice of two (2) Providers who are accepting new clients within the travel time limits (sixty (60) minutes Rural). This travel time is measured via public transportation, where available.	LTSS
LTSS network adequacy requirements are based on the full-time equivalent (FTE) calculations developed by the Department for services where the Provider is traveling to the Participant. FTE network adequacy data must be submitted by CHC zone.	LTSS
For Participants needing anesthesia for dental care, the CHC-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay Out-of-Network.	Dental
Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this Community HealthChoices zone.	Rehabilitation facilities

Pennsylvania Network Access Standards	Applicable Provider Types
The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services, provided FQHC and RHC services are available, within a travel time of thirty (30) minutes (Urban) . If the CHC-MCO's Primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC- MCO must demonstrate in writing it has attempted to reasonably contract in good faith.	Federally Qualified Health Centers
The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services, provided FQHC and RHC services are available, within a travel time of sixty (60) minutes (Rural). If the CHC-MCO's Primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC-MCO must demonstrate in writing it has attempted to reasonably contract in good faith.	Federally Qualified Health Centers
Emergency Medical condition cases must be immediately seen or referred to an emergency facility.	Primary Care Providers
Urgent Medical Condition cases must be scheduled within twenty- four (24) hours.	Primary Care Providers
Non-Urgent Sick Visits must be scheduled with a PCP within seventy-two (72) hours of request, as clinically indicated.	Primary Care Providers
Routine appointments must be scheduled within ten (10) business days. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.	Primary care providers
Emergency Medical Condition appointments immediately upon referral.	Specialist
Urgent Medical Condition care appointments within twenty-four (24) hours of referral.	Specialist
Scheduling of appointments for routine care shall be scheduled to occur within thirty (30) days for all specialty Provider types.	Specialist

VI. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 25** displays the MCO's opportunities as well as IPRO's assessment of their responses. In addition to the opportunities identified from the EQR, DHS also required MCOs to develop a root cause analysis around select P4P indicators.

Current and Proposed Interventions

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

UPMC Response to Previous EQR Recommendations

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

Table 25: UPMC Response to Previous EQR Recommendations

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

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

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

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

UPMC Strengths and Opportunities for Improvement and EQR Recommendations

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

EQR Activity		Quality	Timeliness	Access
Strengths				
PIPs	The MCO scored 100% compliance on both the clinical and non-clinical PIPs for the current RY.	✓	-	-
Performance Measures and CAHPS	The MCO had strengths in performance measure areas: Behavioral Health, Care Coordination, Diabetes, and Prevention and Screening.	✓	✓	✓
Compliance with Medicaid Managed Care Regulations	The MCO was found to be compliant across all applicable items directly associated with CFR Categories for Subparts B, C, D, and E that were subject to review in RY 2022.	✓	✓	✓
Opportunities				
PIPs	There are no opportunities related to PIPs for the current RY.	-	-	-
Performance Measures and CAHPS	The MCO had opportunities for improvement in performance measure areas: Access to/Availability of Services, Long-Term Services and Supports, Overuse/Appropriateness, and Prevention and Screening. The MCO had additional opportunities for improvement from the Adult CAHPS survey.	✓	✓	✓
Compliance with Medicaid Managed Care Regulations	There are no opportunities related to compliance for the MCO.	-	-	-
Recommendations				
PIPs	There are no recommendations related to PIP submissions for the current RY.	-	-	-
Performance Measures and CAHPS	The MCO should improve their rates across several HEDIS performance measure domains and the AADV performance measure. It is recommended that the MCO continue to improve their CAHPS rates.	✓	✓	✓
Compliance with Medicaid Managed Care Regulations	There are no recommendations related to compliance for the MCO.	-	-	-

EQR: external quality review; PIP: performance improvement project; RY: report year; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

P4P Measure Matrix Report Card MY 2022

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

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

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

Table 27: MY 2022 P4P Indicators

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

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

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

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

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

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

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

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

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

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

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

UPMC Key Points

- **A – Benchmark is met. MCO achieved optimal improvement.**

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

- Comprehensive Assessment and Update
- Shared Care Plan with Primary Care Practitioner

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

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

- No MY 2022 measures fell in this category.

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

- Comprehensive Care Plan Update
- Reassessment and Care Plan Update After Inpatient Discharge

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

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

- Overall Satisfaction with Health Plan

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

- No MY 2022 measures fell in this category.

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

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

- PCSP Included All Things Important to You

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

- Number of participants who successfully transitioned from the NF to the community

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

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

- No MY 2022 measures fell in this category.

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

Figure 1: P4P Performance Indicator Matrix

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

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

Table 28: UPMC MY 2022 P4P Results

Indicator Description	MY 2022 Benchmark Goal	MY 2022 Performance Results	Benchmark Goal Met (Yes or No)	MY 2021 Performance Results	MY 2022 Performance Results	Goal Met (Yes or No)	Percentage Change
	UPMC Benchmark Standard			UPMC Improvement Standard			
Comprehensive Assessment and Update (CAU)	78.0%	96.9%	Yes	88.5%	96.9%	Yes	8.4
Comprehensive Care Plan Update (CPU)	78.0%	76.0%	No	63.7%	76.0%	Yes	12.3
Reassessment and Care Plan Update After Inpatient Discharge (RAC)	38.0%	37.5%	No	17.7%	37.5%	No	19.8
Shared Care Plan with Primary Care Practitioner (SCP)	55.0%	64.6%	Yes	54.3%	64.6%	Yes	10.3
Overall Satisfaction with Health Plan (aligned SNP/Medicaid only population)	83.0%	90.5%	Yes	91.3%	90.5%	No	-0.8
Person-Centered Services Plan Included All Things Important to You	70.0%	66.0%	No	66.0%	66.0%	No	0.0
Number of participants successfully transitioned from the NF to the community and remained there for at least six months.	380	409	Yes	474	409	No	-13.7

SNP: special needs plan; NF: nursing facility

Appendix

A1 Performance Improvement Project Interventions

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

Appendix Table 1

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

Summary of Interventions
Empower participants and/or families with communication tools/materials to successfully collaborate with the direct care worker/agency to have a positive, constructive, and engaging relationship in select regions.
Enhanced monitoring of participants discharged from PICs to participants residing in NFs not participating in PIC program in select regions.

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