Commonwealth of Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

2021 External Quality Review Report
Geisinger Health Plan

Final Report
April 2022

IPRO
Better healthcare, realized.

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Introduction

Purpose and Background

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

The Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) contracted with IPRO as its EQRO to conduct the 2021 EQRs (Review Period: 1/1/2020 – 12/31/2020) for the HealthChoices PH MCOs and to prepare the technical reports. HealthChoices Physical Health (PH) is the mandatory managed care program that provides Medical Assistance (MA) recipients with physical health services in PA.

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

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

It should be noted that a fourth mandatory activity, validation of network adequacy, was named in the CMS *External Quality Review (EQR) Protocols* published in October 2019. However, CMS has not published an official protocol for this activity, and this activity is conducted at the state's discretion. Each managed care program agreement entered into by DHS identifies network adequacy standards for those programs. For PH MCOs, DHS has published multiple provider network standards through its Exhibit AAA: Provider Network Composition/Service Access; MCOs submit annual geographic access reports as outlined in these standards. DHS uses a web-based program to assist with ongoing network compliance and during the review year, its monitoring team planned implementation of new methods of verification, such as Access to Care campaigns, network spot checks, and provider directory reviews.

This technical report includes six core sections:

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

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

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

For the PH Medicaid MCOs, the information for the compliance with Structure and Operations Standards in **Section III** of the report is derived from the commonwealth's monitoring of the MCOs against the Systematic Monitoring, Access and

Retrieval Technology (SMART) standards, from the HealthChoices Agreement, and from National Committee for Quality Assurance (NCQA™) accreditation results for each MCO. This section also contains discussion of the revisions to the required structure and compliance standards presented in the updated EQR protocols.

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

Section V has a summary of the MCO's strengths and opportunities for improvement for this review period as determined by IPRO and a "report card" of the MCO's performance as related to selected HEDIS measures**. Section VI** provides a summary of EQR activities for the PH MCO for this review period.

I: Validation of Performance Improvement Projects

Objectives

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

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each Medicaid PH MCO. For the purposes of the EQR, PH MCOs were required to participate in studies selected by OMAP for validation by IPRO in 2020 for 2019 activities. Under the applicable HealthChoices Agreement with the DHS in effect during this review period, Medicaid PH MCOs are required to conduct focused studies each year. For all PH MCOs, two PIPs were initiated as part of this requirement in 2020. For all PIPs, PH MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the EQR PIP cycle that was initiated for all PH MCOs in 2020, PH MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: "Preventing Inappropriate Use or Overuse of Opioids" and "Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits".

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

In addition to increased collection of national measures, DHS has implemented mechanisms to examine other issues related to opioid use disorder (OUD) and coordinated treatment. In 2016, the governor of PA implemented the Centers of Excellence (COE) for Opioid Use Disorder program. Prior to COE implementation, 48% of Medicaid enrollees received OUD treatment, whereas after one year of implementation, 71% received treatment. Additionally, the DHS Quality Care Hospital Assessment Initiative, which focuses on ensuring access to quality hospital services for Pennsylvania Medical Assistance (MA) beneficiaries, was reauthorized in 2018 and included the addition of an Opioid Use Disorder (OUD) incentive. The incentive, based on follow up within 7 days for opioid treatment after a visit to the emergency department (ED) for opioid use disorder, allows hospitals the opportunity to earn incentives by implementing defined clinical pathways to help them get more individuals with OUD into treatment. The DHS also worked with the University of Pittsburgh to analyze OUD treatment, particularly MAT, for PA Medicaid enrollees. Among the findings presented in January 2020 were that the number of Medicaid enrollees receiving medication for OUD more than doubled from 2014-2018, and that the increase was driven by office-based prescriptions for buprenorphine or naltrexone, was seen for nearly all demographic sub-groups, and was higher for rural areas. Similarly, under the Drug and Treatment Act (DATA), prescription rates for buprenorphine have increased. This act allows qualifying practitioners to prescribe buprenorphine for OUD treatment from 30 up to 275 patients and is another component of DHS' continuum of care.

Because opioid misuse and abuse is a national crisis, and due to the impact this has had particularly on PA, the new PH PIP is centered on opioids in the following four common outcome objectives: opioid prevention, harm reduction,

coordination/facilitation into treatment, and increase medicated-assisted treatment (MAT) utilization. For this PIP, the four outcome measures discussed above will be collected and in consideration of the initiatives already implemented in PA, three process oriented measures related to these initiatives will also be collected, focusing on the percentage of individuals with OUD who get into MAT, the duration of treatment for those that get into MAT, and follow-up after an emergency department (ED) visit for OUD. MCOs will define these three measures for their PIPs.

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

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

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

"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits" was selected again due to several factors. General findings and recommendations from the PA Rethinking Care Program (RCP) – Serious Mental Illness (SMI) Innovation Project (RCP-SMI) and Joint PH/BH Readmission projects, as well as overall statewide readmission rates and results from several applicable HEDIS and PA Performance Measures across multiple years have highlighted this topic as an area of concern to be addressed for improvement. For the recently completed Readmissions PIP, several performance measures targeted at examining preventable hospitalizations and ED visits were collected, including measures collected as part of the PH-MCO and BH-MCO Integrated Care Plan (ICP) Program Pay for Performance Program, which was implemented in 2016 to address the needs of individuals with serious persistent mental illness (SPMI). From PIP reporting years 2016 to 2019, results were varied across measures and MCOs. Additionally, from 2017 to 2019, the ICP performance measures targeting the SPMI population showed inconsistent trends and little to no improvement in reducing hospitalizations and ED visits.

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

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

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

- Ambulatory Care (AMB): ED Utilization (HEDIS)
- Inpatient Utilization—General Hospital/Acute Care (IPU): Total Discharges (HEDIS)

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

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

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

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

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

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

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

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/MCP. The technical assistance includes feedback.

CMS's *Protocol 1. Validation of Performance Improvement Projects* was used as the framework to assess the quality of each PIP, as well as to score the compliance of each PIP with both federal and state requirements. IPRO's assessment involves the following 10 elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCO/MCP's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the MCO/MCP's enrollment and generalizable to the MCO/MCP's total population.

4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the PIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the MCO/MCP achieved sustained improvement.

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 utilized during the intervention and sustainability periods. MYs 2019 and 2020 were the baseline year and proposal year and during the 2021 review year, elements were reviewed and scored at multiple points during the year once interim reports were submitted in October 2021. All MCOs received some level of guidance towards improving their proposals in these findings, and MCOs responded accordingly with resubmission to correct specific areas.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points can be awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. For the current PIPs, compliance levels were assessed, but no formal scoring was provided.

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

Table 1.1: Element Designation

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

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. 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%.

Findings

To encourage focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. However, the multiple levels of activity and collaboration between DHS, the PH MCOs, and IPRO continued and progressed throughout the implementation of the PIP cycle during the review year.

The Readmission PIP topic was chosen again due to mixed results across MCOs for the current PIP and because the ICP program remains an important initiative. The Opioid PIP was chosen to address the critical issue of increasing opioid use. Following selection of the topics, IPRO worked with DHS to refine the focus and indicators.

For the Readmission PIP, DHS determined that the ICP measures would be defined and collected by the MCOs for the PIP. This was done to address challenges with the previous PIP and to give MCOs more control and increased ability to implement interventions to directly impact their population. Rates for the ICP program are calculated by IPRO annually during late fourth quarter, using PA PROMISe encounters submitted by both the PH MCOs and the BH MCOs. Because the rates are produced late in the year, and because PH MCOs do not have consistent access to BH encounter data, MCOs have experienced some difficulty implementing interventions to have a timely impact on their population. However, to keep the ICP population consistent, MCOs were provided with the methodology used in the program to define members with SPMI. Additionally, as discussions continued around the multiple factors that contribute to preventable admission and readmission, DHS requested that discussion of social determinants of health (SDoH) be included, as the conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes; differences in health are striking in communities with poor SDoH.

For the Opioid PIP, in order to develop a comprehensive project, DHS initially selected several measures to focus not only on opioid use but also on measures that might be impacted by changes in opioid use. IPRO researched opioid PIPs in other states and discovered that most attempted to first focus on impacting opioid use metrics. This, coupled with Lean guidance that suggests the use of fewer measures to target interventions and change more directly, led to the selection of HEDIS and CMS opioid-related measures. Upon further internal discussion, DHS wanted to ensure that MCOs were using and incorporating DHS opioid-related initiatives, including the PA Centers of Excellence (COE) for Opioid Use Disorder program and incentives under the DHS Quality Care Hospital Assessment Initiative. To this end, DHS added three process oriented measures related to current PA initiatives.

For both PIPs, in light of the current health crisis and ongoing adverse impacts, DHS required MCOs to expand efforts to address health disparities. For a number of the PIP indicators, the PH MCOs already provide member level data files that are examined by race/ethnicity breakdowns and are part of ongoing quality discussions between DHS and PH MCOs. To expand on this for each PIP project, PH MCOs were instructed that they will need to identify race/ethnicity barriers and identify interventions that will be implemented to remediate the barriers identified.

Throughout 2021, the second year of the cycle, there were several levels of communication provided to MCOs after their Project Proposal submissions and in preparation for their Interim submissions, including:

- MCO-specific review findings for each PIP, including detailed information to assist MCOs in preparing their interim resubmissions.
- Conference calls as requested with each MCO to discuss the PIP interim review findings with key MCO staff assigned to each PIP topic.

In response to the feedback provided. MCOs were requested to revise and resubmit their documents to address the identified issues and to be reviewed again. PIP-specific calls were held with each MCO that experienced continued difficulty, attended by both DHS and IPRO. Additionally, as needed, PA DHS discusses ongoing issues with MCOs as part of their regularly scheduled monitoring calls. As noted above, for the current review year, 2021, MCOs were requested to submit a Project Interim Report, including baseline and updated interim rates. Review teams consisted of one clinical staff member and one analytical staff member. Following initial review, MCOs were asked to update their submission according to the recommendations noted in the findings. **Table A.1.1** of the MCO's interventions for the project can be found in the **Appendix** of this report.

Preventing Inappropriate Use or Overuse of Opioids

Geisinger Health Plan's (GEI's) baseline proposal demonstrated that the topic reflects high-volume/ high risk conditions for the population under review. The MCO included an analysis of its membership that quantifies prevalence of OUD and opioid plus benzodiazepines utilization per 1,000 members. Upon proposal review, it was recommended that the MCO strengthen the rationale by providing specific, quantifiable, definitions of GEI membership at risk, including, for example, characterizations by age, sex, race, ethnicity, residence, or SDOH attributes, and that the MCO provide MCO-specific data related to disease prevalence and/or appropriate treatment. In its resubmission, GEI provided information regarding membership but did not add the MCO prevalence or treatment data, so this remains a recommendation.

GEI provided aims and objectives statements in which they describe the interventions they plan to implement and how the interventions will improve rates for the performance indicators. However, the MCO should improve the aims and objectives statements by including interventions that directly address Performance Indicator 2, Use of Opioids from Multiple Providers, Performance Indicator 5, Percent of Individuals with OUD who receive MAT, and Performance Indicator 6, Use of Pharmacotherapy for Opioid Use Disorder. Additionally, the intervention regarding opioid coalitions is not addressed. Each performance indicator should be addressed by a statement, or summary statements, of aims and objectives. Guidance was given to GEI regarding how to format aims and objectives statements with performance indicators within the template to ensure inclusion and alignment of all components. The recommended improvements were not addressed in the resubmission.

For the Preventing Inappropriate Use or Overuse of Opioids PIP, seven performance measures were predetermined by DHS and were identified in the template distributed across MCOs, some with multiple indicators. Four measures are to be collected via HEDIS or the CMS Core Set. The remaining three were to be defined by the MCO. MCOs were to include clear definitions for all. As noted during the baseline review, the information provided by GEI does not include all indicators; Performance Indicators 2, 3 (Risk of Continued Opioid Use), and 6 have multiple indicators that should be included in the PIP. Additionally, Performance Indicator 6 was missing baseline and target rates, with the MCO stating that the data could not be validated. However, it is unclear why the data could not be validated, as the baseline year is the 2019 calendar year. Further, following the comments in the baseline review of the PIP, the MCO should clarify which rates will be reported for this measure. For Performance Indicator 7, Follow-Up Treatment within 7 Days after ED Visit for Opioid Use Disorder, the MCO references the Quality Compass in the target rate rationale. It is important to note that the indicator is an MCO-defined measure, not HEDIS. It is acceptable to use HEDIS for target benchmarks, but the MCO must be careful to specify measures and benchmarks as it is not a direct comparison.

The MCO should include measures that are clearly defined and measurable. Indicators should measure changes in health status, functional status, and satisfaction or processes of care with strong associations with improved outcomes. Upon proposal review, it was recommended that GEI update Performance Indicator 4, Concurrent Use of Opioids and Benzodiazepines, such that the eligible population and denominator only consist of those members with opioid prescriptions. The recommendation was not addressed in the resubmission. Once the updates have been implemented, the specifications should allow for indicators to be measured consistently over time, in order to provide a clear trend with potential actionable information.

The MCO's study design specifies data collection methodologies that are valid and reliable, along with robust data analysis procedures. However, a revision to intervention dates is recommended, such that the intervention start dates within the timeline are consistent with the start dates of the planned interventions.

Barriers were identified through review of pharmacy claims, ED utilization, and treatment resources, as well as communications with law enforcement and EMS agencies. Five interventions addressed provider education, member outreach, and MCO work with police, EMS, and opioid coalitions. However, the interventions were not clearly defined and/or measurable. It was suggested that GEI revise the interventions by developing corresponding intervention tracking measures for each intervention. Additionally, all intervention start dates were planned for 2021. The MCO was advised to start some of the interventions as soon as possible so that they can have an impact on the 2020 interim measurement rates.

Lastly, it was noted that when correcting the baseline and target rates for Indicator 6, the MCO should be careful to carry the rates over as applicable within the submission template and to provide applicable descriptions.

In October 2021, GEI submitted an Interim report for this project. The MCO updated its topic section to include information specific to its membership population, which further illuminated high-volume and high-risk conditions in the MCO's specific population. A comparison of baseline MCO rates to national or state benchmarks was not included in the October 2021 Interim report. Regarding the alignment of aims, objectives, and interventions for this project, it was

reiterated that each performance indicator should be addressed by stating the amount of improvement sought, and the interventions that will be used to achieve this improvement. Performance improvement could not be evaluated.

GEI was encouraged to further develop barriers and methods of barrier analysis. Barriers 1 (provider education) and 2 (Emergency Department utilization for opioid use) are outcomes, not barriers. Interventions and their corresponding tracking measures (ITMs) required additional information, including descriptions for all numerators and denominators for tracking measures, and consistent numbering throughout to allow for logical flow when reading the MCO's report. Many ITMs were found to be underdeveloped or missing key information. GEI provided data from the annual performance indicators, as well as target rates for each indicator to track progress. No Discussion section was included in GEI's Interim Report. **Table A.1.1** of the MCO's interventions for the project can be found in the **Appendix** of this report.

The following recommendations were identified during the Interim Report review process:

- It was recommended that the MCO review guidance provided during the Proposal period regarding the inclusion of MCO baseline rates in discussion around why this project topic is an area of opportunity for GEI. It was recommended that the amount of improvement sought for this project, along with the interventions that will be used to achieve this improvement, be stated clearly in the report.
- It was recommended that GEI utilize formal root cause analyses such as the 5 Whys and other modalities to determine underlying causes of their barriers.
- It was recommended that the MCO implement the specific guidance provided regarding their selected ITMs, including adding definitions for all and ensuring there is an ITM for each intervention that was developed.
- Regarding the data provided in the Results section, it was recommended that an explanation be included as to why the baseline data for Indicator 6 could not be validated.
- It was recommended that GEI complete the Discussion section of the Interim Report in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.

Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits

GEI's baseline proposal for this PIP topic included baseline rates with the potential for meaningful impact on member health, functional status, and satisfaction for the population at hand. It was recommended that the MCO further strengthen the project topic by quantifying volume and the level of risk in its membership. Also, they should provide member data for disease prevalence or acute-care utilization, which would include information about racial disparities evident in prevalence or utilization to identify populations at risk and target interventions. This recommendation was not addressed.

The aims and objectives statements that the MCO provided specified performance indicators for improvement with corresponding goals, and objectives that align the aim and goals with the interventions that have been developed. During the baseline review, it was noted that the MCO should ensure that each performance indicator is addressed by a statement, or summary statements, of aims and objectives. Further, ED, Inpatient Utilization, and Readmissions were addressed, but Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Adherence to Antipsychotic Medications, and all indicators referencing members with SPMI were not addressed. In the revised submission, GEI added aims and objective statements, but did not frame them with descriptions of how the interventions will improve rates for the performance indicators.

Similar to the Preventing Inappropriate Use or Overuse of Opioids PIP, for the Reducing Potentially Preventable Hospital Admissions, Readmissions, and ED visits PIP, DHS selected eight performance measures to be included in the PIPs across all MCOs. Three measures are to be collected via HEDIS. The remaining five, all ICP measures, are to be defined by the MCO with certain predetermined parameters. Most of the proposal review recommendations provided to GEI were not addressed. As noted in the PIP review, Performance Indicator 4, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, is missing the baseline rate. Likewise, Performance Indicator 8, Inpatient 30-Day Readmission Rate for Individuals with SPMI, is missing the baseline and target rates. It should be noted that, as indicated in the proposal documents to the MCOs and training, both Indicators 4 and 8 are required for the PIP and are required to be

defined and collected by the MCO, using data from their own systems. Additionally, Performance Indicator 1, Ambulatory Care: Emergency Department Visits, Indicator 2, Inpatient Utilization: Total Discharges, Indicator 4, and Indicator 7, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, have rationales for their target rates that reference the Quality Compass. It is recommended that the MCO clarify if the target rates are referencing the HEDIS 2020 (MY 2019) Quality Compass year. In addition, percentiles should be specified in the target rate rationales for Performance Indicators 1 and 4.

In the PIP, the MCO should provide performance indicators that are clearly defined and measurable; plus they should measure changes in health status, functional status, and satisfaction or processes of care with strong associations with improved outcomes. However, it is recommended that GEI update Performance Indicator 1 such that the denominator reflects the total member months, as opposed to the total ED visits per 1,000 member months, which is the description of the measure, not the denominator. Further, Performance Indicator 2 should be revised to reflect total member months as well. The MCO should also define the SPMI criteria for the applicable measures, as referenced in the PIP baseline review. Once the MCO incorporates these recommendations, the specifications should allow for indicators to be measured consistently over time, in order to provide a clear trend with potential actionable information. Additionally, the MCO's study design specifies data collection methodologies that are valid and reliable, along with robust data analysis procedures.

The barrier analysis and subsequent barriers were identified through claims review and risk stratification, member outreach, SDOH assessment, and Care Management process review. The PIP consists of four member interventions and no provider interventions. It is recommended that the MCO include interventions that target active provider outreach and education. In addition, specific interventions were highlighted for GEI to include corresponding intervention tracking measures, so that all interventions are clearly defined and/or measurable. Further, for the Community Health Assistant Referral Intervention, the proportion reported in the ITM should be redefined and recalculated, such that the numerator is a subset of the denominator. Also, to ensure the intent of the intervention is clear, the measurement is correct, and the result is useful, it is recommended that GEI includes item descriptions above the numerators, denominators, and rates for all ITMs.

Lastly, when correcting the baseline and target rates as indicated, the MCO should be careful to carry the rates over as applicable within the submission template and to provide applicable descriptions.

In October 2021, GEI submitted an interim report for this project. During Proposal review, it was recommended that volume and the level of risk in its membership should be quantified in the Project Topic section. Additionally, recommendations were made for GEI to include racial disparities in prevalence or utilization to identify at-risk and target interventions. These recommendations were not incorporated in the MCO's Interim Report. Therefore, performance improvement could not be evaluated. The MCO was encouraged to revisit Indicators 5 (Emergency Room Utilization for Individuals with SPMI) and 6 (Inpatient Admission Utilization for Individuals with SPMI) in order to ensure baseline calculations have been performed correctly.

Upon review of barriers and interventions for the MCO's Interim submission, while the table of interventions was substantially revised in this submission, it was noted that there are no provider interventions included in the project. In addition, ITM 3c while meaningful, has no connection to Barrier 3. Namely, it is addressing medication adherence, not rising risk population identification. For Intervention 4, no ITMs were developed, and many ITMs did not have any descriptions included in the report. Overall, inconsistent ITMs, associated interventions and rates made interpretation of ITMs difficult. No Discussion section was included in GEI's Interim Report. **Table A.1.1** of the MCO's interventions for the project can be found in the **Appendix** of this report.

The following recommendations were identified during the Interim Report review process:

- It was strongly recommended that GEI use the guidance provided during Proposal review in conjunction with the example AIMs statement provided within the PIP template to completely revise the AIMs and Objectives section.

- Regarding target rates, it was recommended that the MCO calculate out all target rates based upon the baseline period data provided.
- It was recommended that the project timeline be updated to reflect specific start dates for better tracking throughout the lifetime of the PIP.
- It was recommended that the MCO consider determining if medication adherence is a true barrier in this population and designating ITM 3c as a separate and independent intervention.
- It was recommended that GEI complete the Discussion section of the Interim Report in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.

GEI's Project Interim compliance assessment by review element is presented in **Table 1.2**.

Table 1.2: GEI PIP Compliance Assessments

Review Element	Preventing Inappropriate Use or Overuse of Opioids	Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits
1. Project Topic	Partial	Partial
2. Methodology	Partial	Partial
3. Barrier Analysis, Interventions and Monitoring	Partial	Partial
4. Results	Partial	Partial
5. Discussion	Not Met	Not Met
6. Next Steps	N/A	N/A
7. Validity and Reliability of PIP Results	N/A	N/A

PIP: performance improvement project; ED: emergency department.

II: Performance Measures and CAHPS Survey

Objectives

IPRO validated PA-specific performance measures and HEDIS data for each of the Medicaid PH MCOs.

The MCOs were provided with final specifications for the PA Performance Measures from December 2020 to June 2021. Source code, raw data, and rate sheets were submitted by the MCOs to IPRO for review in 2021. A staggered submission was implemented for the performance measures. IPRO conducted an initial validation of each measure including source code review and provided each MCO with formal written feedback. The MCOs were then given the opportunity for resubmission, if necessary, with a limit of four total submissions. Additional resubmissions required discussion with and approval from DHS. Pseudo code was reviewed by IPRO. Raw data were also reviewed for reasonability, and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally, MCOs were provided with comparisons to the previous year's rates and were requested to provide explanations for highlighted differences. For measures reported as percentages, differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates. For measures not reported as percentages (e.g., adult admission measures), differences were highlighted based only on statistical significance, with no minimum threshold.

For the PA performance Birth-related measure, Elective Delivery, rates are typically produced utilizing MCO Birth files in addition to the final Department of Health Birth File. IPRO requested, from each MCO, information on members with a live birth within the measurement year. IPRO would then typically utilize the MCO file in addition to the most recent applicable PA Department of Health Birth File to identify the denominator, numerator, and rate for the measure. However, due to issues with the COVID-19 pandemic the final 2021 (MY 2020) Department of Health Birth File was not available at the time of reporting. This measure was not reported and is therefore not included in this section.

HEDIS MY 2020 measures were validated through a standard HEDIS compliance audit of each PH MCO. The audit protocol includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of the Interactive Data Submission System (IDSS). For HEDIS MY 2020, audit activities were performed virtually due to the public health emergency. A Final Audit Report was submitted to NCQA for each MCO. Because the PA-specific performance measures rely on the same systems and staff, no separate review was necessary for validation of PA-specific measures. IPRO conducts a thorough review and validation of source code, data, and submitted rates for the PA-specific measures.

Evaluation of MCO performance is based on both PA-specific performance measures and selected HEDIS measures for the EQR. It is DHS's practice to report all first-year performance measures for informational purposes. Relevant context regarding reported rates or calculated averages is provided as applicable, including any observed issues regarding implementation, reliability, or variability among MCOs. Additional discussion regarding MCO rates that differ notably from other MCOs will be included in the MCO-specific findings as applicable. A list of the performance measures included in this year's EQR report is presented in **Table 2.1**.

Table 2.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 45–64 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 65+ years)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total Ages 1 to 17)
Well-Care Visits and Immunizations	
HEDIS	Well-Child Visits in the First 30 Months of Life (15 months ≥6 Visits)
HEDIS	Well-Child Visits in the First 30 Months of Life (15 to 30 months ≥2 visits)
HEDIS	Child and Adolescent Well-Care Visits (Ages 3 to 11 years)

Source	Measures
HEDIS	Child and Adolescent Well-Care Visits (Ages 12 to 17 years)
HEDIS	Child and Adolescent Well-Care Visits (Ages 18 to 21 years)
HEDIS	Child and Adolescent Well-Care Visits (Total)
HEDIS	Childhood Immunizations Status (Combination 2)
HEDIS	Childhood Immunizations Status (Combination 3)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index: Percentile (Ages 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index: Percentile (Ages 12–17 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index: Percentile (Total)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 12–17 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Total)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Ages 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Ages 12–17 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total)
HEDIS	Immunizations for Adolescents (Combination 1)
EPSDT: Screenings and Follow-up	
HEDIS	Lead Screening in Children (Ages 2 years)
HEDIS	Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase
HEDIS	Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase
PA EQR	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (BH Enhanced)—Initiation Phase
PA EQR	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (BH Enhanced)—Continuation and Maintenance Phase
PA EQR	Developmental Screening in the First Three Years of Life—Total
PA EQR	Developmental Screening in the First Three Years of Life—1 year
PA EQR	Developmental Screening in the First Three Years of Life—2 years
PA EQR	Developmental Screening in the First Three Years of Life—3 years
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 18 to 64—ED visits for mental illness, follow-up within 7 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 18 to 64—ED visits for mental illness, follow-up within 30 days)
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 65 and older—ED visits for mental illness, follow-up within 30 days)

Source	Measures
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 65 and older—ED visits for mental illness, follow-up within 7 days)
Dental Care for Children and Adults	
HEDIS	Annual Dental Visit (Ages 2–20 years)
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Ages 2–20 years)
PA EQR	Sealant Receipt on Permanent First Molars (≥ 1 molar)
PA EQR	Sealant Receipt on Permanent First Molars (All 4 molars)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 21–35 years)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 36–59 years)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 60–64 years)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 65 years and older)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 21 years and older)
PA EQR	Adult Annual Dental Visit: Women with a Live Birth (Ages 21–35 years)
PA EQR	Adult Annual Dental Visit: Women with a Live Birth (Ages 36–59 years)
PA EQR	Adult Annual Dental Visit: Women with a Live Birth (Ages 21–59 years)
Women's Health	
HEDIS	Breast Cancer Screening (Ages 50–74 years)
HEDIS	Cervical Cancer Screening (Ages 21–64 years)
HEDIS	Chlamydia Screening in Women (Total)
HEDIS	Chlamydia Screening in Women (Ages 16–20 years)
HEDIS	Chlamydia Screening in Women (Ages 21–24 years)
HEDIS	Non-Recommended Cervical Cancer Screening in Adolescent Females
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 21 to 44)
Obstetric and Neonatal Care	
HEDIS	Prenatal and Postpartum Care—Timeliness of Prenatal Care
HEDIS	Prenatal and Postpartum Care—Postpartum Care
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS)

Source	Measures
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke Exposure (ETS)
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
PA EQR	Perinatal Depression Screening: Prenatal Screening Positive for Depression
PA EQR	Perinatal Depression Screening: Prenatal Counseling for Depression
PA EQR	Perinatal Depression Screening: Postpartum Screening for Depression
PA EQR	Perinatal Depression Screening: Postpartum Screening Positive for Depression
PA EQR	Perinatal Depression Screening: Postpartum Counseling for Depression
Respiratory Conditions	
HEDIS	Appropriate Testing for Pharyngitis (Ages 3- 17 years)
HEDIS	Appropriate Testing for Pharyngitis (Ages 18-64 years)
HEDIS	Appropriate Testing for Pharyngitis (Ages 65 years and older)
HEDIS	Appropriate Testing for Pharyngitis (Total)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 3 months – 17 years)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 18-64 years)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 65 years and older)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Total)
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months-17 years)
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18-64 years)
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65 years and older)
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
HEDIS	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
HEDIS	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
HEDIS	Asthma Medication Ratio (5–11 years)
HEDIS	Asthma Medication Ratio (12–18 years)
HEDIS	Asthma Medication Ratio (19–50 years)
HEDIS	Asthma Medication Ratio (51–64 years)
HEDIS	Asthma Medication Ratio (Total)
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 2–17 years)—Admission per 100,000 member months
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 18–39 years)—Admission per 100,000 member months
PA EQR	Asthma in Children and Younger Adults Admission Rate (Total Ages 2–39 years)—Admission per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years)—Admission per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older)—Admission per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total 40+ years)—Admission per 100,000 member months
Comprehensive Diabetes Care	
HEDIS	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
HEDIS	Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)

Source	Measures
HEDIS	Comprehensive Diabetes Care: HbA1c Control (< 8.0%)
HEDIS	Comprehensive Diabetes Care: Retinal Eye Exam
HEDIS	Comprehensive Diabetes Care: Blood Pressure Controlled < 140/90 mm Hg
PA EQR	Diabetes Short-Term Complications Admission Rate (Ages 18–64 years)—Admission per 100,000 member months
PA EQR	Diabetes Short-Term Complications Admission Rate (Ages 65+ years)—Admission per 100,000 member months
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years)—Admission per 100,000 member months
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Ages Cohort: 18–64 Years of Ages)
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Ages Cohort: 65–75 Years of Ages)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (18–64 years)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (65–74 years)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (75–85 years)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Total Ages 18–85 years)
Cardiovascular Care	
HEDIS	Persistence of Beta-Blocker Treatment After Heart Attack
HEDIS	Controlling High Blood Pressure (Total Rate)
PA EQR	Heart Failure Admission Rate (Ages 18–64 years)—Admission per 100,000 member months
PA EQR	Heart Failure Admission Rate (Ages 65+ years)—Admission per 100,000 member months
PA EQR	Heart Failure Admission Rate (Total Ages 18+ years)—Admission per 100,000 member months
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21–75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40–75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—21–75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—40–75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—Total Rate
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
HEDIS	Cardiac Rehabilitation Initiation >2 visits in 30 days (Ages 18–64 years)
HEDIS	Cardiac Rehabilitation Initiation >2 visits in 30 days (Ages 65 years and older)
HEDIS	Cardiac Rehabilitation Initiation >2 visits in 30 days (Total 18 years and older)
HEDIS	Cardiac Rehabilitation Engagement 1 >12 visits in 90 days (Ages 18–64 years)
HEDIS	Cardiac Rehabilitation Engagement 1 >12 visits in 90 days (Ages 65 years and older)
HEDIS	Cardiac Rehabilitation Engagement 1 >12 visits in 90 days (Total 18 years and older)
HEDIS	Cardiac Rehabilitation Engagement 2 >24 visits in 180 days (Ages 18–64 years)
HEDIS	Cardiac Rehabilitation Engagement 2 >24 visits in 180 days (Ages 65 years and older)
HEDIS	Cardiac Rehabilitation Engagement 2 >24 visits in 180 days (Total 18 years and older)
HEDIS	Cardiac Rehabilitation Achievement >36 visits in 180 days (Ages 18–64 years)
HEDIS	Cardiac Rehabilitation Achievement >36 visits in 180 days (Ages 65 years and older)
HEDIS	Cardiac Rehabilitation Achievement >36 visits in 180 days (Total 18 years and older)
Utilization	
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1–11 years)

Source	Measures
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Ages 1–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Ages 1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Ages 12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Ages 1–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Ages 1–17 years)
HEDIS	Use of Opioids at High Dosage
HEDIS	Use of Opioids from Multiple Providers (4 or more prescribers)
HEDIS	Use of Opioids from Multiple Providers (4 or more pharmacies)
HEDIS	Use of Opioids from Multiple Providers (4 or more prescribers & pharmacies)
HEDIS	Risk of Continued Opioid Use—New Episode Lasts at Least 15 Days (Ages 18–64 years)
HEDIS	Risk of Continued Opioid Use—New Episode Lasts at Least 15 Days (Ages 65 years and older)
HEDIS	Risk of Continued Opioid Use—New Episode Lasts at Least 15 Days (Total Ages 18 years and older)
HEDIS	Risk of Continued Opioid Use—New Episode Lasts at Least 31 Days (Ages 18–64 years)
HEDIS	Risk of Continued Opioid Use—New Episode Lasts at Least 31 Days (Ages 65 years and older)
HEDIS	Risk of Continued Opioid Use—New Episode Lasts at Least 31 Days (Total Ages 18 years and older)
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Ages 18–64 years)
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Ages 65 years and older)
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Total Ages 18 years and older)
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 16–64 years)
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 65+ years)
HEDIS	Pharmacotherapy for Opioid Use Disorder (Total Ages 16+ years)
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Total)
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Oral Naltrexone)
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Long-Acting, Injectable Naltrexone)
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Methadone)
Utilization (Continued)	
HEDIS	Plan All-Cause Readmissions: Count of Index Hospital Stays (IHS)—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions: Count of 30-Day Readmissions—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions: Observed Readmission Rate—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions: Expected Readmission Rate—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions: Observed to Expected Readmission Ratio—Total Stays (Ages Total)

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

PA-Specific and CMS Core Set Performance Measure Selection and Descriptions

Several PA-specific performance measures were calculated by each MCO and validated by IPRO. In accordance with DHS direction, IPRO created the indicator specifications to resemble HEDIS specifications. Measures previously developed and added, as mandated by CMS for children in accordance with the Children's Health Insurance Program

Reauthorization Act (CHIPRA) and for adults in accordance with the Affordable Care Act (ACA), were continued as applicable to revised CMS specifications. Additionally, new measures were developed and added in 2021 as mandated in accordance with the CMS specifications. The CMS measures are known as Core Set measures and are indicated below for children and adults. For each indicator, the eligible population is identified by product line, age, enrollment, anchor date, and event/diagnosis. Administrative numerator positives are identified by date of service, diagnosis/procedure code criteria, as well as other specifications, as needed. For 2021 (MY 2020), these performance measure rates were calculated through one of two methods: (1) administrative, which uses only the MCO's data systems to identify numerator positives and (2) hybrid, which uses a combination of administrative data and medical record review (MRR) to identify numerator "hits" for rate calculation.

A number of performance measures require the inclusion of PH and BH services. Due to the separation of PH and BH services for Medicaid, DHS requested that IPRO utilize encounters submitted by all PH and BH MCOs to DHS via the PROMISe encounter data system to ensure both types of services were included, as necessary. For some measures, IPRO enhanced PH data submitted by MCOs with BH PROMISe encounter data, while for other measures, IPRO collected and reported the measures using PROMISe encounter data for both the BH and PH data required.

PA-Specific and CMS Core Set Administrative Measures

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—CHIPRA Core Set
This performance measure assesses the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.

Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—CHIPRA Core Set
DHS enhanced this measure using behavioral health (BH) encounter data contained in IPRO's encounter data warehouse. IPRO evaluated this measure using HEDIS 2021 Medicaid member-level data submitted by the PH MCO.

This performance measure assesses the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed. Two rates are reported:

- Initiation Phase—The percentage of children 6 to 12 years old as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
- Continuation and Maintenance (C&M) Phase—The percentage of children 6 to 12 years old as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and, who in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Developmental Screening in the First Three Years of Life—CHIPRA Core Set
This performance measure assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. Four rates—one for each age group and a combined rate—are calculated and reported.

Follow-up After Emergency Department Visit for Mental illness—Adult Core Set
This performance measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit with a corresponding principal diagnosis for mental illness. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data. Two rates are reported:

- The percentage of ED visits for mental illness for which the member received follow-up within 7 days of the ED visit (8 total days); and
- The percentage of ED visits for mental illness for which the member received follow-up within 30 days of the ED visit (31 total days).

Per the CMS specifications, rates are reported for age cohorts 18 to 64 and 65 and older.

Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—Adult Core Set
This performance measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and who had a follow-up visit with a corresponding principal diagnosis for AOD abuse or dependence. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data. Two rates are reported:

- The percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 7 days of the ED visit (8 total days); and
- The percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 30 days of the ED visit (31 total days).

Per the CMS specifications, rates are reported for age cohorts 18 to 64 and 65 and older.

Annual Dental Visits for Enrollees with Developmental Disabilities—PA-specific
This performance measure assesses the percentage of enrollees with a developmental disability age 2 through 20 years of age who were continuously enrolled and had at least one dental visit during the measurement year. This indicator utilizes the HEDIS MY 2020 measure Annual Dental Visit (ADV).

Sealant Receipt on Permanent First Molars—CHIPRA Core Set — New for 2021
This performance measure assesses the percentage of enrolled children who have ever received sealants on permanent first molar teeth and turned 10 years old during the measurement year. Two rates are reported:

- The percentage of enrolled children who received a sealant on at least one permanent first molar in the 48 months prior to their 10th birthday; and
- The percentage of unduplicated enrolled children who received sealants on all four permanent first molars in the 48 months prior to their 10th birthday.

Adult Annual Dental Visit ≥ 21 Years—PA-specific
This performance measure assesses two indicators:

- The percentage of enrollees 21 years of age and above who were continuously enrolled during the calendar year 2020. Five rates will be reported: one for each of the four age cohorts (21–35, 36–59, 60–64, and 65+ years) and a total rate.
- The percentage of women 21 years of age and older with a live birth that had at least one dental visit during the measurement year. Three rates will be reported for Indicator 2: one for each of the two age cohorts for women with a live birth (21—39 and 40—59 years) and a total rate.

Contraceptive Care for All Women Ages 15–44—CMS Core Measure
This performance measure assesses the percentage of women ages 15 to 44 at risk of unintended pregnancy who were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC). Four rates are reported—two rates for each of the age groups (15–20 and 21–44): (1) provision of most or moderately effective contraception, and (2) provision of LARC.

Contraceptive Care for Postpartum Women Ages 15–44—CMS Core Measure
This performance measure assesses the percentage of women ages 15 to 44 who had a live birth and were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC) within 3 days and within 60 days of delivery. Eight rates are reported—four rates for each of the age groups (15–20 and 21–44): (1) Most or moderately effective contraception—3 days, (2) Most or moderately effective contraception—60 days, (3) LARC—3 days, and (4) LARC—60 days.

Asthma in Children and Younger Adults Admission Rate—Adult Core Set and PA-specific
This performance measure assesses the number of discharges for asthma in enrollees ages 2 years to 39 years per 100,000 Medicaid member months. Three age groups are reported: ages 2–17 years, ages 18–39 years, and total ages 2–39 years.

Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate—Adult Core Set
This performance measure assesses the number of discharges for chronic obstructive pulmonary disease (COPD) or asthma for Medicaid members 40 years and older per 100,000 member months. Three age groups are reported: ages 40–64 years, age 65 years and older, and 40+ years.

Diabetes Short-Term Complications Admission Rate—Adult Core Set
This performance measure assesses the number of discharges for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) in adults 18 years and older per 100,000 Medicaid member months. Three age groups are reported: ages 18–64 years, age 65 years and older, and 18+ years.

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)—Adult Core Set
This performance measure assesses the percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement years was > 9.0%. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.

Heart Failure Admission Rate—Adult Core Set
This performance measure assesses the number of discharges for heart failure in adults 18 years and older per 100,000 Medicaid member months. Three age groups are reported: ages 18–64 years, ages 65 years and older, and 18+ years.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia—Adult Core Set
This performance measure assesses the percentage of members 18 years of age and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period during the measurement year. Members in hospice are excluded from the eligible population.

DHS enhanced this measure using behavioral health (BH) encounter data contained in IPRO's encounter data warehouse.

Concurrent Use of Opioids and Benzodiazepines—Adult Core Set
This performance measure assesses the percentage of members 18 years of age and above with concurrent use of prescription opioids and benzodiazepines. Three age groups are reported: ages 18–64 years, age 65 years and older, and 18+ years.

Use of Pharmacotherapy for Opioid Use Disorder—Adult Core Set
This performance measure assesses the percentage of members ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported: a total rate including any medications used in medication-assisted treatment of opioid dependence and addiction, and four separate rates representing the following FDA-approved drug products: (1) buprenorphine; (2) oral naltrexone; (3) long-acting, injectable naltrexone; and (4) methadone.

PA Specific Hybrid Measures

Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit—PA-specific
This performance measure assesses the percentage of pregnant enrollees who were:

1. Screened for smoking during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the MCO.
2. Screened for smoking during the time frame of one of their first two prenatal visits (CHIPRA indicator).

3. Screened for environmental tobacco smoke exposure during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the MCO.
4. Screened for smoking in one of their first two prenatal visits who smoke (i.e., smoked six months prior to or anytime during the current pregnancy), that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy.
5. Screened for environmental tobacco smoke exposure in one of their first two prenatal visits and found to be exposed, that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy.
6. Screened for smoking in one of their first two prenatal visits and found to be current smokers (i.e., smoked at the time of one of their first two prenatal visits) that stopped smoking during their pregnancy.

This performance measure uses components of the HEDIS MY 2020 Prenatal and Postpartum Care Measure.

Perinatal Depression Screening—PA-specific
This performance measure assesses the percentage of enrollees who were:

1. Screened for depression during a prenatal care visit.
2. Screened for depression during a prenatal care visit using a validated depression screening tool.
3. Screened for depression during the time frame of the first two prenatal care visits (CHIPRA indicator).
4. Screened positive for depression during a prenatal care visit.
5. Screened positive for depression during a prenatal care visit and had evidence of further evaluation, treatment, or referral for further treatment.
6. Screened for depression during a postpartum care visit.
7. Screened for depression during a postpartum care visit using a validated depression screening tool.
8. Screened positive for depression during a postpartum care visit.
9. Screened positive for depression during a postpartum care visit and had evidence of further evaluation, treatment, or referral for further treatment.

This performance measure uses components of the HEDIS MY 2020 Prenatal and Postpartum Care Measure.

HEDIS Performance Measure Selection and Descriptions

Each MCO underwent a full HEDIS compliance audit in 2021. As indicated previously, performance on selected HEDIS measures is included in this year's EQR report. Development of HEDIS measures and the clinical rationale for their inclusion in the HEDIS measurement set can be found in HEDIS MY 2020, Volume 2 Narrative. The measurement year for the HEDIS measures is 2020, as well as prior years for selected measures. Each year, DHS updates its requirements for the MCOs to be consistent with NCQA's requirement for the reporting year. MCOs are required to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the HEDIS Technical Specifications, Volume 2. In addition, DHS does not require the MCOs to produce the Chronic Conditions component of the CAHPS 5.1H—Child Survey.

Adults' Access to Preventive/Ambulatory Health Services
This measure assesses the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year (for Medicaid or Medicare). The following age groups are reported: 20–44, 45–64, and 65+.

Adult Body Mass Index (BMI) Assessment
This measure assesses the percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Well-Child Visits in the First 30 Months of Life – New for 2021
This measure assesses the percentage of members who turned 30 months old during the measurement year, who were continuously enrolled from 31 days of age through 30 months of age, and who:

- Received six or more well-child visits with a PCP during their first 15 months of life; and
- Received two or more well-child visits for age 15 months-30 months of life.

Childhood Immunization Status (Combos 2 and 3)
This measure assesses the percentage of children who turned 2 years of age in the measurement year, who were continuously enrolled for the 12 months preceding their second birthday, and who received one or both of two immunization combinations on or before their second birthday. Separate rates were calculated for each Combination. Combination 2 and Combination 3 consist of the following immunizations:

- (4) Diphtheria, Tetanus, and Acellular Pertussis Vaccine/Diphtheria and Tetanus (DTaP/DT);
- (3) Injectable Polio Vaccine (IPV);
- (1) Measles, Mumps, and Rubella (MMR);
- (3) Haemophilus Influenza Type B (HiB);
- (3) Hepatitis B (HepB);
- (1) Chicken Pox (VZV); and
- (4) Pneumococcal Conjugate Vaccine (PCV)—Combination 3 only.

Child and Adolescent Well-Care Visits – New for 2021
This measure assesses the percentage of enrolled members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
This measure assesses the percentage of members 3–17 years of age, who had an outpatient visit with a PCP or OB/GYN, and who had evidence of the following during the measurement year:

- BMI percentile documentation;
- Counseling for nutrition; and
- Counseling for physical activity.

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Immunization for Adolescents (Combo 1)
This measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday.

Lead Screening in Children
This measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Follow-up Care for Children Prescribed ADHD Medication
This measure assesses the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- Initiation Phase—The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- Continuation and Maintenance (C&M) Phase—The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Annual Dental Visit
This measure assesses the percentage of children and adolescents 2–20 years of age who were continuously enrolled in the MCO for the measurement year and who had at least one dental visit during the measurement year.

Breast Cancer Screening
This measure assesses the percentage of women ages 50–74 who had a mammogram to screen for breast cancer.

The eligible population for this measure is women 52–74 years of age as of December 31 of the measurement year. Members are included in the numerator if they had one or more mammograms any time on or between October 1 in the 2 years prior to the measurement year and December 31 of the measurement year. Eligible members who received mammograms beginning at age 50 are included in the numerator.

Cervical Cancer Screening
This measure assesses the percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria:

- Women ages 21–64 who had cervical cytology performed within the last 3 years;
- Women ages 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years; or
- Women ages 30–64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Chlamydia Screening in Women
This measure assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Three age cohorts are reported: 16–20 years, 21–24 years, and total.

Non-Recommended Cervical Cancer Screening in Adolescent Females
This measure assesses the percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. For this measure, a lower rate indicates better performance.

Prenatal and Postpartum Care
This measure assesses the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- Timeliness of Prenatal Care—The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization; and
- Postpartum Care—The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Appropriate Testing for Pharyngitis
This measure assesses the percentage of episodes for members 3 years and older for which the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing). The total rate is reported.

Appropriate Treatment for Upper Respiratory Infection
This measure assesses the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. The measure is reported as an inverted rate (1 − [numerator/eligible population]). A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed). The total rate is reported.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
This measure assesses the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. The measure is reported as an inverted rate

(1 − [numerator/eligible population]). A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed). The total rate is reported.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD
This measure assesses the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

Pharmacotherapy Management of COPD Exacerbation
This measure assesses the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event; and
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Asthma Medication Ratio
This measure assesses the percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The following age groups are reported: 5–11 years, 12–18 years, 19–50 years, 51–64 years, and total years.

Comprehensive Diabetes Care
This measure assesses the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing;
- HbA1c poor control (> 9.0%);
- HbA1c control (< 8.0%);
- Eye exam (retinal) performed; and
- BP control (< 140/90 mm Hg).

Statin Therapy for Patients with Diabetes
This measure assesses the percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

- Received Statin Therapy—Members who were dispensed at least one statin medication of any intensity during the measurement year; and
- Statin Adherence 80%—Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Kidney Health Evaluation for Patients with Diabetes — New for 2021
This measure assesses the percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. The following age groups are reported: 18–64 years, 65–74 years, 75–85 years, and total years.

Persistence of Beta-Blocker Treatment After a Heart Attack
This measure assesses the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for 6 months after discharge.

Controlling High Blood Pressure
This measure assesses the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year.

Statin Therapy for Patients with Cardiovascular Disease
This measure assesses the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

- Received Statin Therapy—Members who were dispensed at least one high- or moderate-intensity statin medication during the measurement year; and
- Statin Adherence 80%—Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.

Total rates for both submeasures are also reported.

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
This measure assesses the percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease who had an LDL-C test during the measurement year.

Cardiac Rehabilitation — New for 2021
This measure assesses the percentage of members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Three age groups (18–64 years, 65 years and older, and total years) are reported for each of the following four rates:

- *Initiation*. The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- *Engagement 1.* The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
- *Engagement 2*. The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
- *Achievement*. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia
This measure assesses the percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Metabolic Monitoring for Children and Adolescents on Antipsychotics
This measure assesses the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported for each age group (1–11 years, 12–17 years, and total):

- The percentage of children and adolescents on antipsychotics who received blood glucose testing;
- The percentage of children and adolescents on antipsychotics who received cholesterol testing; and
- The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Use of Opioids at High Dosage
This measure assesses the proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

For this measure, a lower rate indicates better performance.

Use of Opioids from Multiple Providers
This measure assesses the proportion of members 18 years and older who received prescription opioids for ≥ 15 days during the measurement year and who received opioids from multiple providers. Three rates are reported:

- Multiple Prescribers—The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year;
- Multiple Pharmacies—The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year; and
- Multiple Prescribers and Multiple Pharmacies—The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

Risk of Continued Opioid Use
This measure assesses the percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

- The percentage of members with at least 15 days of prescription opioids in a 30-day period; and
- The percentage of members with at least 31 days of prescription opioids in a 62-day period.

Pharmacotherapy for Opioid Use Disorder
This measure assesses the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.

Plan All-Cause Readmissions
The measure assesses, for members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported for the total index hospital stays in the following categories:

- Count of Index Hospital Stays (IHS) (denominator);
- Count of 30-Day Readmissions (numerator);
- Observed Readmission Rate;
- Expected Readmissions Rate; and
- Observed to Expected Readmission Ratio.

CAHPS Survey
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is overseen by the Agency of Healthcare Research and Quality (AHRQ) and includes many survey products designed to capture consumer and patient perspectives on health care quality. NCQA uses the adult and child versions of the CAHPS Health Plan surveys for HEDIS.

Implementation of PA-Specific Performance Measures and HEDIS Audit

The MCO successfully implemented all of the PA-specific measures for 2021 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures. As previously indicated for the Elective Delivery measure, due to issues with the COVID-19 pandemic the final 2021 (MY 2020) Department of Health Birth File was not available for IPRO to calculate the measure at the time of reporting; this measure is not reported.

The MCO successfully completed the HEDIS audit. The MCO received an Audit Designation of Report for all applicable measures.

Conclusions and Comparative Findings

MCO results are presented in **Table 2.2** through **Table 2.12**. For each measure, the denominator, numerator, and measurement year 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% confidence interval 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 confidence interval 95 times, or 95% of the time.

Rates for both the measurement year and the previous year are presented, as available (i.e., 2021 [MY 2020] and 2020 [MY 2019]). In addition, statistical comparisons are made between the MY 2020 and MY 2019 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 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."

In addition to each individual MCO's rate, the MMC average for 2021 (MY 2020) is presented. The MMC average is a weighted average, which is an average that takes into account the proportional relevance of each MCO. Each table also presents the significance of difference between the plan's measurement year rate and the MMC average for the same year. For comparison of MY 2020 rates to MMC rates, "+" denotes that the plan rate exceeds the MMC rate, "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power, and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage point difference between two rates was statistically significant in many cases, although not meaningful. Hence, results corresponding to each table highlight only differences that are both statistically significant and display at least a 3-percentage point difference in observed rates. It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates might not yield statistical significance due to reduced power; if statistical significance is not achieved, results are not highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, "N/A" (Not Applicable) appears in the corresponding cells. However, "NA" (Not Available) also appears in the cells under the HEDIS MY 2020 percentile column for PA-specific measures that do not have HEDIS percentiles to compare.

Table 2.5 to **Table 2.12** show rates up to one decimal place. Calculations to determine differences between rates are based upon unrounded rates. Due to rounding, differences in rates that are reported in the narrative may differ slightly from the difference between rates presented in the table.

As part of IPRO's validation of GEI's Performance Measures and CAHPS Survey results, the following are recommended areas of focus for the plan moving into the next reporting year. Particular attention has been paid to measures that are not only identified as opportunities for the current 2021 review year, but were also identified as opportunities in 2020.

- It is recommended that GEI improve access to annual dental visits for its members. The measures Annual Dental Visit (Age 2–20 years) and Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years) were both opportunities in 2020 and again in 2021. Both measures have reported rates that decreased in 2021.
- It is recommended that the MCO improve screening access for their members, particular around women's health. The measure Chlamydia Screening in Women was an opportunity in 2020 for all age cohorts, and was identified as an opportunity again in 2021.
- It is recommended that GEI improve access to contraceptive care for postpartum women. The Contraceptive Care for Postpartum Women: LARC - 60 days measure for ages 15 to 20 and 21 to 44 decreased in 2021, and were opportunities in 2020 and 2021.

Access to/Availability of Care

Strengths are identified for the following Access to/Availability of Care performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years) – 6.3 percentage points;
  - Adults' Access to Preventive/Ambulatory Health Services (Age 45-64 years) – 4.1 percentage points;
  - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years) – 6.4 percentage points; and
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11) – 9.6 percentage points.

No opportunities for improvement are identified for the Access to/Availability of Care measures.

Table 2.2: Access to/Availability of Care

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 20-44 years)	57,328	46,686	**81.4%**	81.1%	81.8%	84.2%	-	75.2%	+	>= 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 45-64 years)	27,707	24,110	**87.0%**	86.6%	87.4%	89.0%	-	82.9%	+	>= 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 65+ years)	493	393	**79.7%**	76.1%	83.4%	85.7%	-	73.3%	+	>= 25th and < 50th percentile
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11)	203	157	**77.3%**	71.3%	83.3%	76.4%	n.s.	67.7%	+	NA
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)	255	159	**62.4%**	56.2%	68.5%	73.6%	-	63.8%	n.s.	NA
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)	458	316	**69.0%**	64.7%	73.3%	74.7%	-	65.1%	n.s.	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare.

Well-Care Visits and Immunizations

Strengths are identified for the following Well-Care Visits and Immunizations performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Well-Child Visits in the First 30 Months of Life (15-30 months ≥ 2 Visits) – 3.1 percentage points;
  - Child and Adolescent Well-Care Visits (12-17 years) – 3.5 percentage points;
  - Body Mass Index: Percentile (Age 3 - 11 years) – 4.6 percentage points;
  - Body Mass Index: Percentile (Age 12-17 years) – 9.0 percentage points;
  - Body Mass Index: Percentile (Total) – 6.1 percentage points;
  - Counseling for Physical Activity (Age 3-11 years) – 4.9 percentage points; and
  - Counseling for Physical Activity (Total) – 3.5 percentage points.

No opportunities for improvement are identified for the Well-Care Visits and Immunizations measures.

Table 2.3: Well-Care Visits and Immunizations

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Well-Child Visits in the First 30 Months of Life (15 months ≥ 6 Visits)	4,489	2,981	**66.4%**	65.0%	67.8%	74.1%	-	65.2%	n.s.	>= 75th and < 90th percentile
HEDIS	Well-Child Visits in the First 30 Months of Life (15-30 months ≥ 2 Visits)	4,085	3,174	**77.7%**	76.4%	79.0%	N/A	N/A	74.6%	+	>= 75th and < 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (3-11 years)	40,538	25,241	**62.3%**	61.8%	62.7%	N/A	N/A	60.5%	+	>= 75th and < 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (12-17 years)	25,888	15,068	**58.2%**	57.6%	58.8%	N/A	N/A	54.7%	+	>= 75th and < 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (18-21 years)	12,985	4,725	**36.4%**	35.6%	37.2%	N/A	N/A	35.0%	+	>= 75th and < 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (Total)	79,411	45,034	**56.7%**	56.4%	57.1%	N/A	N/A	54.6%	+	>= 75th and < 90th percentile
HEDIS	Childhood Immunizations Status (Combination 2)	411	316	**76.9%**	72.7%	81.1%	75.4%	n.s.	74.6%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunizations Status (Combination 3)	411	307	**74.7%**	70.4%	79.0%	72.0%	n.s.	72.1%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Body Mass Index: Percentile (Age 3 - 11 years)	233	199	**85.4%**	80.7%	90.2%	88.3%	n.s.	80.8%	+	>= 75th and < 90th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Body Mass Index: Percentile (Age 12-17 years)	138	118	**85.5%**	79.3%	91.7%	86.2%	n.s.	76.5%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Body Mass Index: Percentile (Total)	371	317	**85.4%**	81.7%	89.2%	87.5%	n.s.	79.3%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Nutrition (Age 3-11 years)	233	179	**76.8%**	71.2%	82.5%	76.2%	n.s.	74.7%	+	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Nutrition (Age 12-17 years)	138	100	**72.5%**	64.6%	80.3%	69.0%	n.s.	71.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Nutrition (Total)	371	279	**75.2%**	70.7%	79.7%	73.4%	n.s.	73.6%	+	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Physical Activity (Age 3-11 years)	233	170	**73.0%**	67.0%	78.9%	66.2%	n.s.	68.1%	+	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Physical Activity (Age 12-17 years)	138	98	**71.0%**	63.1%	78.9%	70.3%	n.s.	70.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Physical Activity (Total)	371	268	**72.2%**	67.5%	76.9%	67.8%	n.s.	68.8%	+	>= 50th and < 75th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Immunizations for Adolescents (Combo 1)	411	361	**87.8%**	84.5%	91.1%	90.0%	n.s.	87.6%	n.s.	>= 75th and < 90th percentile

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable.

EPSDT: Screenings and Follow-up

Strengths are identified for the following EPSDT: Screenings and Follow-up performance measures.

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Lead Screening in Children (Age 2 years) – 5.1 percentage points;
  - Developmental Screening in the First Three Years of Life - Total – 4.2 percentage points;
  - Developmental Screening in the First Three Years of Life - 1 year – 5.5 percentage points;
  - Developmental Screening in the First Three Years of Life - 2 years – 3.2 percentage points;
  - Developmental Screening in the First Three Years of Life - 3 years – 4.3 percentage points;
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days) – 19.1 percentage points; and
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days) – 15.8 percentage points.

No opportunities for improvement are identified for the EPSDT: Screenings and Follow-up measures.

Table 2.4: EPSDT: Screenings and Follow-up

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Lead Screening in Children (Age 2 years)	411	363	**88.3%**	85.1%	91.5%	82.2%	+	83.2%	+	>= 90th percentile
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	1,141	541	**47.4%**	44.5%	50.4%	40.6%	+	47.5%	n.s.	>= 50th and < 75th percentile
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Continuation Phase	452	211	**46.7%**	42.0%	51.4%	41.6%	n.s.	52.8%	n.s.	>= 25th and < 50th percentile
PA EQR	Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Initiation Phase	1,250	598	**47.8%**	45.0%	50.6%	42.8%	+	47.4%	n.s.	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Continuation Phase	490	236	**48.2%**	43.6%	52.7%	42.9%	n.s.	52.3%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life—Total	12,990	8,298	**63.9%**	63.0%	64.7%	65.4%	-	59.6%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life—1 year	4,467	2,724	**61.0%**	59.5%	62.4%	64.0%	-	55.5%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life—2 years	4,355	2,780	**63.8%**	62.4%	65.3%	67.3%	-	60.7%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life—3 years	4,168	2,794	**67.0%**	65.6%	68.5%	65.0%	n.s.	62.8%	+	NA
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 18 to 64—ED visits for mental illness, follow-up within 7 days)	866	533	**61.6%**	58.3%	64.8%	61.2%	n.s.	42.4%	+	NA
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 18 to 64—ED visits for mental illness, follow-up within 30 days)	866	614	**70.9%**	67.8%	74.0%	70.7%	n.s.	55.1%	+	NA
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 7 days)	938	182	**19.4%**	16.8%	22.0%	17.7%	n.s.	21.8%	n.s.	NA
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 30 days)	938	286	**30.5%**	27.5%	33.5%	28.1%	n.s.	31.5%	n.s.	NA
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for AOD abuse or dependence, follow-up within 30 days)	0	0	**N/A**	N/A	N/A	N/A	N/A	11.8%	N/A	NA
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 65 and older—ED visits for mental illness, follow-up within 30 days)	0	0	**N/A**	N/A	N/A	N/A	N/A	85.7%	N/A	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for AOD abuse or dependence, follow-up within 7 days)	0	0	**N/A**	N/A	N/A	N/A	N/A	11.8%	N/A	NA
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages: 65 and older—ED visits for mental illness, follow-up within 7 days)	0	0	**N/A**	N/A	N/A	N/A	N/A	85.7%	N/A	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Dental Care for Children and Adults

Strengths are identified for the following Dental Care for Children and Adults performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Sealant Receipt on Permanent First Molars (≥ 1 Molar) – 15.0 percentage points; and
  - Sealant Receipt on Permanent First Molars (All 4 Molars) – 14.2 percentage points.

Opportunities for improvement are identified for the following Dental Care for Children and Adults measures:

- The following rates are statistically significantly below/worse than the 2021 (MY 2020) MMC weighted average:
  - Annual Dental Visit (Age 2–20 years) – 8.5 percentage points;
  - Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years) – 9.0 percentage points;
  - Adult Annual Dental Visit ≥ 21 Years (Age 65 years and older) – 3.8 percentage points; and
  - Adult Annual Dental Visit Women with a Live Birth (Age 36-59 years) – 5.6 percentage points.

Table 2.5: EPSDT: Dental Care for Children and Adults

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Annual Dental Visit (Ages 2–20 years)	80,983	37,038	**45.7%**	45.4%	46.1%	54.4%	-	54.2%	-	>= 25th and < 50th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Ages 2–20 years)	5,739	2,670	**46.5%**	45.2%	47.8%	54.3%	-	55.5%	-	NA
PA EQR	Sealant Receipt on Permanent First Molars (≥ 1 Molar)	3,521	1,628	**46.2%**	44.6%	47.9%	N/A	N/A	31.3%	+	NA
PA EQR	Sealant Receipt on Permanent First Molars (All 4 Molars)	3,521	1,237	**35.1%**	33.5%	36.7%	N/A	N/A	20.9%	+	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 21–35 years)	35,504	9,674	**27.3%**	26.8%	27.7%	32.3%	-	27.4%	n.s.	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 36–59 years)	38,846	9,776	**25.2%**	24.7%	25.6%	29.5%	-	25.0%	n.s.	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 60–64 years)	5,845	1,242	**21.3%**	20.2%	22.3%	24.9%	-	21.4%	n.s.	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 65 years and older)	488	55	**11.3%**	8.4%	14.2%	17.1%	-	15.0%	-	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 21 years and older)	80,683	20,747	**25.7%**	25.4%	26.0%	30.3%	-	25.7%	n.s.	NA
PA EQR	Adult Annual Dental Visit Women with a Live Birth (Ages 21-35 years)	2,795	787	**28.2%**	26.5%	29.8%	N/A	N/A	29.1%	n.s.	NA
PA EQR	Adult Annual Dental Visit Women with a Live Birth (Ages 36-59 years)	324	78	**24.1%**	19.3%	28.9%	N/A	N/A	29.7%	-	NA
PA EQR	Adult Annual Dental Visit Women with a Live Birth (Ages 21-59 years)	3,119	865	**27.7%**	26.1%	29.3%	N/A	N/A	29.1%	n.s.	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable.

Women's Health

Strengths are identified for the following Women's Health performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Breast Cancer Screening (Age 50-74 years) – 3.7 percentage points; and
  - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20) – 3.9 percentage points.

Opportunities for improvement are identified for the following Women's Health measures:

- The following rates are statistically significantly below/worse than the 2021 (MY 2020) MMC weighted average:
  - Chlamydia Screening in Women (Total) – 5.5 percentage points;
  - Chlamydia Screening in Women (Age 16-20 years) – 6.3 percentage points;
  - Chlamydia Screening in Women (Age 21-24 years) – 4.3 percentage points;
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20) – 5.2 percentage points;
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20) – 7.3 percentage points;
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21 to 44) – 4.6 percentage points; and
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44) – 5.5 percentage points.

Table 2.6: Women's Health

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Breast Cancer Screening (Ages 50–74 years)	7,482	4,252	**56.8%**	55.7%	58.0%	60.6%	-	53.2%	+	>= 50th and < 75th percentile
HEDIS	Cervical Cancer Screening (Ages 21–64 years)	380	237	**62.4%**	57.4%	67.4%	64.3%	n.s.	61.1%	+	>= 50th and < 75th percentile
HEDIS	Chlamydia Screening in Women (Total)	9,106	4,689	**51.5%**	50.5%	52.5%	54.7%	-	57.0%	-	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Ages 16–20 years)	5,073	2,401	**47.3%**	45.9%	48.7%	50.2%	-	53.7%	-	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Ages 21–24 years)	4,033	2,288	**56.7%**	55.2%	58.3%	60.4%	-	61.0%	-	>= 25th and < 50th percentile
HEDIS	Non-Recommended Cervical Cancer Screening in Adolescent Females[2]	9,043	127	**1.4%**	1.2%	1.6%	2.0%	-	0.4%	+	< 10th percentile
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)	10,679	3,755	**35.2%**	34.3%	36.1%	38.4%	-	31.3%	+	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)	10,679	304	**2.8%**	2.5%	3.2%	3.5%	-	3.3%	-	NA
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)	31,886	8,939	**28.0%**	27.5%	28.5%	29.7%	-	27.6%	n.s.	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)	31,886	1,211	**3.8%**	3.6%	4.0%	4.4%	-	4.4%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 15 to 20)	273	34	**12.5%**	8.4%	16.6%	4.8%	+	16.2%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 15 to 20)	273	116	**42.5%**	36.4%	48.5%	45.2%	n.s.	47.2%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 15 to 20)	273	11	**4.0%**	1.5%	6.5%	0.6%	+	9.2%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 15 to 20)	273	26	**9.5%**	5.9%	13.2%	10.3%	n.s.	16.8%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 21 to 44)	2,536	424	**16.7%**	15.2%	18.2%	6.8%	+	19.3%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 21 to 44)	2,536	1,081	**42.6%**	40.7%	44.6%	37.2%	+	44.8%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 21 to 44)	2,536	30	**1.2%**	0.7%	1.6%	0.5%	+	5.7%	-	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 21 to 44)	2,536	176	**6.9%**	5.9%	7.9%	6.9%	n.s.	12.4%	-	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
[2] For the Non-Recommended Cervical Cancer Screening in Adolescent Females measure, lower rate indicates better performance.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare.

Obstetric and Neonatal Care

Strengths are identified for the following Obstetric and Neonatal Care performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking – 10.2 percentage points;
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 11.1 percentage points;
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure – 7.5 percentage points;
  - Perinatal Depression Screening: Prenatal Screening for Depression – 5.2 percentage points;
  - Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 15.7 percentage points;
  - Perinatal Depression Screening: Prenatal Screening Positive for Depression – 5.5 percentage points; and
  - Perinatal Depression Screening: Postpartum Screening Positive for Depression – 5.2 percentage points.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2021 (MY 2020) MMC weighted average:
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation – 9.2 percentage points.

Table 2.7: Obstetric and Neonatal Care

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Prenatal and Postpartum Care—Timeliness of Prenatal Care	411	363	**88.3%**	85.1%	91.5%	91.7%	n.s.	88.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Prenatal and Postpartum Care—Postpartum Care	411	318	**77.4%**	73.2%	81.5%	82.0%	n.s.	77.8%	n.s.	>= 50th and < 75th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking	423	364	**86.1%**	82.6%	89.5%	N/A	N/A	75.9%	+	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	423	364	**86.1%**	82.6%	89.5%	N/A	N/A	74.9%	+	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure	423	232	**54.9%**	50.0%	59.7%	N/A	N/A	47.4%	+	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking	141	116	**82.3%**	75.6%	88.9%	N/A	N/A	80.2%	n.s.	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke Exposure	97	80	**82.5%**	74.4%	90.6%	N/A	N/A	80.0%	n.s.	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation	132	19	**14.4%**	8.0%	20.8%	N/A	N/A	23.6%	-	NA
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression	423	302	**71.4%**	67.0%	75.8%	N/A	N/A	66.2%	+	NA
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	423	293	**69.3%**	64.8%	73.8%	N/A	N/A	53.6%	+	NA
PA EQR	Perinatal Depression Screening: Prenatal Screening Positive for Depression	302	82	**27.2%**	22.0%	32.3%	N/A	N/A	21.6%	+	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Perinatal Depression Screening: Prenatal Counseling for Depression	82	56	**68.3%**	57.6%	79.0%	N/A	N/A	77.9%	n.s.	NA
PA EQR	Perinatal Depression Screening: Postpartum Screening for Depression	352	262	**74.4%**	69.7%	79.1%	N/A	N/A	71.4%	n.s.	NA
PA EQR	Perinatal Depression Screening: Postpartum Screening Positive for Depression	262	59	**22.5%**	17.3%	27.8%	N/A	N/A	17.4%	+	NA
PA EQR	Perinatal Depression Screening: Postpartum Counseling for Depression	59	49	**83.1%**	72.6%	93.5%	N/A	N/A	85.1%	n.s.	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "−" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable.

Respiratory Conditions

Strengths are identified for the following Respiratory Conditions performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Appropriate Testing for Pharyngitis (Age 18-64 years) – 3.1 percentage points;
  - Asthma Medication Ratio (5-11 years) – 6.4 percentage points;
  - Asthma Medication Ratio (12-18 years) – 4.6 percentage points;
  - Asthma in Younger Adults Admission Rate (Age 2-17 years) per 100,000 member months – 5.0 percentage points;
  - Asthma in Younger Adults Admission Rate (Total Age 2-39 years) per 100,000 member months – 3.3 percentage points;
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months – 7.9 percentage points;
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months – 13.9 percentage points; and
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months – 8.0 percentage points.

Opportunities for improvement are identified for the following Respiratory Conditions measures:

- The following rates are statistically significantly below/worse than the 2021 (MY 2020) MMC weighted average:
  - Appropriate Treatment for Upper Respiratory Infection (Age 3 months-17 years) – 3.0 percentage points;

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Age 3 months-17 years) – 10.8 percentage points; and
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total) – 5.1 percentage points.

Table 2.8: Respiratory Conditions

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Appropriate Testing for Pharyngitis (Total—Ages 3 - 17 years)	6,035	4,890	**81.0%**	80.0%	82.0%	77.4%	+	82.1%	n.s.	>= 25th and < 50th percentile
HEDIS	Appropriate Testing for Pharyngitis (Ages 18-64 years)	2,764	1,732	**62.7%**	60.8%	64.5%	64.4%	n.s.	59.6%	+	>= 25th and < 50th percentile
HEDIS	Appropriate Testing for Pharyngitis (Ages 65+ years)	3	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Appropriate Testing for Pharyngitis (Total)	8,802	6,622	**75.2%**	74.3%	76.1%	73.7%	+	74.2%	n.s.	>= 25th and < 50th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 3 months-17 years)[2]	17,132	1,509	**91.2%**	90.8%	91.6%	90.6%	+	94.2%	-	>= 25th and < 50th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 18-64 years)[2]	6,027	1,188	**80.3%**	79.3%	81.3%	76.5%	+	82.0%	-	>= 50th and < 75th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 65+ years)[2]	13	6	**N/A**	N/A	N/A	N/A	N/A	77.8%	N/A	< 10th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Total)[2]	23,172	2,703	**88.3%**	87.9%	88.8%	87.3%	+	90.9%	-	>= 25th and < 50th percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months-17 years)[3]	1,780	658	**63.0%**	60.8%	65.3%	59.9%	+	73.8%	-	>= 25th and < 50th percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18-64 years)[3]	1,680	878	**47.7%**	45.3%	50.2%	47.0%	n.s.	46.3%	n.s.	>= 75th and < 90th percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65+ years)[3]	5	2	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	>= 75th and < 90th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)[3]	3,465	1,538	**55.6%**	53.9%	57.3%	53.7%	n.s.	60.7%	-	>= 50th and < 75th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	690	212	**30.7%**	27.2%	34.2%	28.6%	n.s.	26.9%	n.s.	>= 75th and < 90th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	444	347	**78.2%**	74.2%	82.1%	76.8%	n.s.	77.2%	n.s.	>= 75th and < 90th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	444	375	**84.5%**	81.0%	87.9%	83.9%	n.s.	87.3%	n.s.	>= 25th and < 50th percentile
HEDIS	Asthma Medication Ratio (5–11 years)	601	505	**84.0%**	81.0%	87.0%	83.5%	n.s.	77.6%	+	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (12–18 years)	740	559	**75.5%**	72.4%	78.7%	73.2%	n.s.	71.0%	+	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (19–50 years)	1,639	939	**57.3%**	54.9%	59.7%	59.3%	n.s.	56.7%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (51–64 years)	424	226	**53.3%**	48.4%	58.2%	60.1%	-	57.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Asthma Medication Ratio (Total)	3,404	2,229	**65.5%**	63.9%	67.1%	67.3%	n.s.	64.8%	n.s.	>= 50th and < 75th percentile
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 2–17 years) per 100,000 member months[4]	860,924	18	**2.1**	N/A	N/A	5.0	-	7.1	-	NA
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 18–39 years) per 100,000 member months[4]	730,402	32	**4.4**	N/A	N/A	4.1	+	5.7	-	NA
PA EQR	Asthma in Children and Younger Adults Admission Rate (Total Ages 2–39 years) per 100,000 member months[4]	1,591,326	50	**3.1**	N/A	N/A	4.6	-	6.5	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years) per 100,000 member months[4]	474,861	161	**33.9**	N/A	N/A	38.4	-	41.8	-	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older) per 100,000 member months[4]	6,085	2	**32.9**	N/A	N/A	88.3	-	46.7	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+) per 100,000 member months[4]	480,946	163	**33.9**	N/A	N/A	39.0	-	41.9	-	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
[2] Per NCQA, a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).
[3] Per NCQA, a higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).
[4] For the Admission Rate measures, lower rates indicate better performance.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Comprehensive Diabetes Care

Strengths are identified for the following Comprehensive Diabetes Care performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - HbA1c Poor Control (>9.0%) – 4.8 percentage points;
  - Retinal Eye Exam – 10.4 percentage points;
  - Blood Pressure Controlled <140/90 mm Hg – 9.4 percentage points; and
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age) – 4.6 percentage points.

Opportunities for improvement are identified for the following Comprehensive Diabetes Care performance measures:

- The following rates are statistically significantly below/worse than the 2021 (MY 2020) MMC weighted average:
  - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months – 4.84 admissions per 100,000 member months; and
  - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months – 4.83 admissions per 100,000 member months.

Table 2.9: Comprehensive Diabetes Care

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing	411	356	**86.6%**	83.2%	90.0%	87.1%	n.s.	83.7%	+	>= 75th and < 90th percentile
HEDIS	Comprehensive Diabetes Care – HbA1c Poor Control (> 9.0%)[2]	411	138	**33.6%**	28.9%	38.3%	29.1%	n.s.	38.4%	-	>= 90th percentile
HEDIS	Comprehensive Diabetes Care – HbA1c Control (< 8.0%)	411	214	**52.1%**	47.1%	57.0%	58.3%	n.s.	51.2%	n.s.	>= 75th and < 90th percentile
HEDIS	Comprehensive Diabetes Care – Retinal Eye Exam	411	262	**63.8%**	59.0%	68.5%	66.5%	n.s.	53.3%	+	>= 90th percentile
HEDIS	Comprehensive Diabetes Care – Blood Pressure Controlled < 140/90 mm Hg	411	310	**75.4%**	71.1%	79.7%	79.0%	n.s.	66.0%	+	>= 90th percentile
PA EQR	Diabetes Short-Term Complications Admission Rate (Ages 18 to 64 years) per 100,000 member months[3]	1,205,263	292	**24.2**	21.4	27.0	28.6	-	19.4	+	NA
PA EQR	Diabetes Short-Term Complications Admission Rate (Ages 65+ years) per 100,000 member months[3]	6,085	0	**0.0**	0.0	0.0	0.0	N/A	5.8	n.s.	NA
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years) per 100,000 member months[3]	1,211,348	292	**24.1**	21.3	26.9	28.4	-	19.3	+	NA
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy	4,138	2,830	**68.4%**	67.0%	69.8%	68.1%	n.s.	69.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%	2,830	2,126	**75.1%**	73.5%	76.7%	71.3%	+	73.8%	n.s.	>= 75th and < 90th percentile
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Ages 18–64 Years)	781	680	**87.1%**	84.7%	89.5%	89.9%	n.s.	82.5%	+	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Ages 65–75 Years)	1	1	**N/A**	N/A	N/A	N/A	N/A	78.1%	N/A	NA
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Ages 18 - 64 years)	8,130	3,291	**40.5%**	39.4%	41.6%	N/A	N/A	38.6%	+	>= 90th percentile
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Ages 65 - 74 years)	93	35	**37.6%**	27.2%	48.0%	N/A	N/A	45.4%	n.s.	>= 90th percentile
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Ages 75 - 85 years)	28	15	**N/A**	N/A	N/A	N/A	N/A	40.5%	n.s.	>= 90th percentile
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Total)	8,251	3,341	**40.5%**	39.4%	41.6%	N/A	N/A	38.7%	+	>= 90th percentile

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

[2] For HbA1c Poor Control, lower rates indicate better performance.

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

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Cardiovascular Care

Strengths are identified for the following Cardiovascular Care performance measures:

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Controlling High Blood Pressure (Total Rate) – 8.1 percentage points;
  - Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months – 4.12 admissions per 100,000 member months; and
  - Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months – 4.24 admissions per 100,000 member months.

No opportunities for improvement are identified for the Cardiovascular Care performance measures.

Table 2.10: Cardiovascular Care

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack	112	101	**90.2%**	84.2%	96.1%	91.3%	n.s.	85.9%	n.s.	>= 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	411	294	**71.5%**	67.0%	76.0%	71.8%	n.s.	63.4%	+	>= 90th percentile
PA EQR	Heart Failure Admission Rate (Ages 18–64 years) per 100,000 member months[2]	1,205,263	192	**15.9**	13.7	18.2	17.2	n.s.	20.0	-	NA
PA EQR	Heart Failure Admission Rate (Ages 65+ years) per 100,000 member months[2]	6,085	5	**82.2**	10.1	154.2	141.2	n.s.	73.4	n.s.	NA
PA EQR	Heart Failure Admission Rate (Total Ages 18+ years) per 100,000 member months[2]	1,211,348	197	**16.3**	14.0	18.5	17.8	n.s.	20.5	-	NA
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21–75 years (Male)	744	636	**85.5%**	82.9%	88.1%	88.1%	n.s.	84.7%	n.s.	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40–75 years (Female)	516	438	**84.9%**	81.7%	88.1%	86.4%	n.s.	81.8%	n.s.	>= 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate	1,260	1,074	**85.2%**	83.2%	87.2%	87.4%	n.s.	83.5%	n.s.	>= 75th and < 90th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—21–75 years (Male)	636	491	**77.2%**	73.9%	80.5%	75.7%	n.s.	76.3%	n.s.	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—40–75 years (Female)	438	341	**77.9%**	73.8%	81.9%	75.4%	n.s.	76.4%	n.s.	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—Total Rate	1,074	832	**77.5%**	74.9%	80.0%	75.6%	n.s.	76.3%	n.s.	>= 75th and < 90th percentile
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia 18-64 years	7	6	**N/A**	N/A	N/A	N/A	N/A	73.0%	N/A	>= 90th percentile
HEDIS	Cardiac Rehabilitation Initiation: ≥ 2 Visits in 30 days (Ages 18 - 64 years)	366	10	**2.7%**	0.9%	4.5%	N/A	N/A	2.0%	n.s.	>= 90th percentile
HEDIS	Cardiac Rehabilitation Initiation: ≥ 2 Visits in 30 days (Ages 65 + years)	3	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Cardiac Rehabilitation Initiation: ≥ 2 Visits in 30 days (Total)	369	10	**2.7%**	0.9%	4.5%	N/A	N/A	2.0%	n.s.	>= 90th percentile
HEDIS	Cardiac Rehabilitation Engagement 1: ≥ 12 Visits in 90 days (Ages 18 - 64 years)	366	10	**2.7%**	0.9%	4.5%	N/A	N/A	2.7%	n.s.	>= 90th percentile
HEDIS	Cardiac Rehabilitation Engagement 1: ≥ 12 Visits in 90 days (Ages 65 + years)	3	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Cardiac Rehabilitation Engagement 1: ≥ 12 Visits in 90 days (Total)	369	10	**2.7%**	0.9%	4.5%	N/A	N/A	2.7%	n.s.	>= 90th percentile
HEDIS	Cardiac Rehabilitation Engagement 2: ≥ 24 Visits in 180 days (Ages 18 - 64 years)	366	9	**2.5%**	0.7%	4.2%	N/A	N/A	2.4%	n.s.	>= 90th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Cardiac Rehabilitation Engagement 2: ≥ 24 Visits in 180 days (Ages 65 + years)	3	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Cardiac Rehabilitation Engagement 2: ≥ 24 Visits in 180 days (Total)	369	9	**2.4%**	0.7%	4.1%	N/A	N/A	2.3%	n.s.	>= 90th percentile
HEDIS	Cardiac Rehabilitation Achievement: ≥ 36 Visits in 180 days (Ages 18 - 64 years)	366	3	**0.8%**	0.0%	1.9%	N/A	N/A	1.1%	n.s.	>= 90th percentile
HEDIS	Cardiac Rehabilitation Achievement: ≥ 36 Visits in 180 days (Ages 65 + years)	3	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Cardiac Rehabilitation Achievement: ≥ 36 Visits in 180 days (Total)	369	3	**0.8%**	0.0%	1.9%	N/A	N/A	1.1%	n.s.	>= 90th percentile

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "−" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
[2] For the Adult Admission Rate measures, lower rates indicate better performance.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Utilization

Strengths are identified for the following Utilization performance measures.

- The following rates are statistically significantly above/better than the 2021 (MY 2020) MMC weighted average:
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Age 12-17 years) – 5.1 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Age 1-17 years) – 5.0 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Age 1-17 years) – 3.8 percentage points;
  - Pharmacotherapy for Opioid Use Disorder (Age 16-64 years) – 7.4 percentage points;
  - Pharmacotherapy for Opioid Use Disorder (Total Age 16+ years) – 7.4 percentage points; and
  - Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine) – 5.0 percentage points.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2021 (MY 2020) MMC weighted average:
  - Concurrent Use of Opioids and Benzodiazepines (Total Age 18 years and older) – 3.4 percentage points.

Table 2.11: Utilization

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	407	251	**61.7%**	56.8%	66.5%	65.3%	n.s.	65.1%	n.s.	>= 25th and < 50th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	743	484	**65.1%**	61.6%	68.6%	69.9%	n.s.	68.1%	n.s.	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1-11 years)	516	366	**70.9%**	66.9%	74.9%	81.0%	-	65.4%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12-17 years)	920	708	**77.0%**	74.2%	79.7%	83.7%	-	71.9%	+	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Ages 1-17 years)	1,436	1,074	**74.8%**	72.5%	77.1%	82.7%	-	69.8%	+	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Ages 1-11 years)	516	346	**67.1%**	62.9%	71.2%	76.7%	-	61.7%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Ages 12-17 years)	920	564	**61.3%**	58.1%	64.5%	69.3%	-	60.3%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Ages 1-17 years)	1,436	910	**63.4%**	60.8%	65.9%	72.0%	-	60.7%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 1-11 years)	516	333	**64.5%**	60.3%	68.8%	74.4%	-	58.4%	n.s.	>= 90th percentile

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 12-17 years)	920	558	**60.7%**	57.4%	63.9%	69.1%	-	58.2%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Ages 1-17 years)	1,436	891	**62.1%**	59.5%	64.6%	71.0%	-	58.2%	+	>= 90th percentile
HEDIS	Use of Opioids at High Dosage[2]	2,032	150	**7.4%**	6.2%	8.5%	7.7%	n.s.	8.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more prescribers)[3]	2,436	333	**13.7%**	12.3%	15.1%	17.6%	-	13.6%	n.s.	>= 75th and < 90th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more pharmacies)[3]	2,436	10	**0.4%**	0.1%	0.7%	1.4%	-	1.4%	n.s.	>= 90th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)[3]	2,436	8	**0.3%**	0.1%	0.6%	0.9%	-	0.7%	n.s.	>= 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 15 Days (Ages 18 - 64 years)[4]	8,724	319	**3.7%**	3.3%	4.1%	4.1%	n.s.	5.1%	-	>= 75th and < 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 15 Days (Ages 65+ years)[4]	9	0	**N/A**	N/A	N/A	N/A	N/A	6.4%	N/A	NA
HEDIS	Risk of Continued Opioid Use - At Least 15 Days (Ages 18 years and older)[4]	8,733	319	**3.7%**	3.3%	4.0%	4.1%	n.s.	5.1%	-	>= 75th and < 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 31 Days (Ages 18 - 64 years)[4]	8,724	168	**1.9%**	1.6%	2.2%	1.9%	n.s.	3.2%	-	>= 75th and < 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 31 Days (Ages 65+ years)[4]	9	0	**N/A**	N/A	N/A	N/A	N/A	3.5%	N/A	NA
HEDIS	Risk of Continued Opioid Use - At Least 31 Days (Ages 18 years and older)[4]	8,733	168	**1.9%**	1.6%	2.2%	1.9%	n.s.	3.2%	-	>= 75th and < 90th percentile
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Ages 18-64 years)[5]	2,131	468	**22.0%**	20.2%	23.7%	20.7%	n.s.	18.6%	+	NA

		2021 (MY 2020)					2021 (MY 2020) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Ages 65 years and older)[5]	6	3	**N/A**	N/A	N/A	N/A	N/A	9.6%	N/A	NA
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Total Ages 18 years and older)[5]	2,137	471	**22.0%**	20.3%	23.8%	20.9%	n.s.	18.6%	+	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 16-64 years)	1,633	564	**34.5%**	32.2%	36.9%	40.8%	-	27.2%	+	>= 50th and < 75th percentile
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 65+ years)	0	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (Total Ages 16+ years)	1,633	564	**34.5%**	32.2%	36.9%	40.8%	-	27.2%	+	>= 50th and < 75th percentile
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Total)	778	612	**78.7%**	75.7%	81.6%	74.1%	+	75.2%	n.s.	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)	778	578	**74.3%**	71.2%	77.4%	70.3%	n.s.	69.3%	+	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Oral Naltrexone)	778	23	**3.0%**	1.7%	4.2%	2.9%	n.s.	4.0%	n.s.	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Long-Acting, Injectable Naltrexone)	778	39	**5.0%**	3.4%	6.6%	4.8%	n.s.	7.0%	n.s.	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Methadone)	778	1	**0.1%**	0.0%	0.4%	0.0%	n.s.	2.5%	-	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

[2] For the Use of Opioids at High Dosage measure, lower rates indicate better performance.

[3] For the Use of Opioids From Multiple Providers measure, lower rates indicate better performance.

[4] For the Risk of Continued Opioid Use measure, lower rates indicate better performance.

[5] For the Concurrent Use of Opioids and Benzodiazepines measure, lower rates indicate better performance.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Table 2.12: Utilization (Continued)

		2021 (MY 2020)		2021 (MY 2020) Rate ComparisonComparison[1]		
Indicator Source	Indicator[2]	Count	Rate	2020 (MY 2019) Rate	2021 Rate Compared to 2020	HEDIS 2021 Percentile
HEDIS	Plan All-Cause Readmissions: Count of Index Hospital Stays (IHS)—Total Stays (Ages Total)	5,193		4,543		NA
HEDIS	Plan All-Cause Readmissions: Count of 30-Day Readmissions—Total Stays (Ages Total)	395		494		NA
HEDIS	Plan All-Cause Readmissions: Observed Readmission Rate—Total Stays (Ages Total)		**7.6%**	10.9%	N/A	NA
HEDIS	Plan All-Cause Readmissions: Expected Readmission Rate—Total Stays (Ages Total)		**9.7%**	10.1%	N/A	NA
HEDIS	Plan All-Cause Readmissions: Observed to Expected Readmission Ratio—Total Stays (Ages Total)		**0.8**	1.1	N/A	NA

[1] For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s." For comparison of MY 2020 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "−" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
[2] For the Plan All-Cause Readmissions (PCR) measure, cells that are grey shaded are data elements that are not relevant to the measure.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

Table 2.13 and **Table 2.14** provide the survey results of four composite questions by two specific categories for GEI across the last 3 measurement years, as available. The composite questions target the MCO's performance strengths as well as opportunities for improvement.

Due to differences in the CAHPS submissions from year to year, direct comparisons of results are not always available. Questions that are not included in the most recent survey version are not presented in **Table 2.13** and **Table 2.14**.

MY 2020 Adult CAHPS 5.1H Survey Results

Table 2.13: CAHPS MY 2020 Adult Survey Results

Survey Section/Measure	2021 (MY 2020)	2021 Rate Compared to 2020	2020 (MY 2019)	2020 Rate Compared to 2019	2019 (MY 2018)	2021 MMC Weighted Average
Your Health Plan						
Satisfaction with Adult's Health Plan (Rating of 8–10)	85.71%	▲	83.72%	▲	82.64%	81.40%
Getting Needed Information (Usually or Always)	88.54%	▼	91.59%	▲	91.46%	84.68%
Your Health Care in the Last 6 Months						
Satisfaction with Health Care (Rating of 8–10)	80.47%	▲	79.70%	▲	74.12%	79.53%
Appointment for Routine Care When Needed (Usually or Always)	85.45%	▲	78.97%	▼	86.73%	82.26%

▲▼ = Performance increased (▲) or decreased (▼) compared to prior year's rate.
Gray shaded boxes reflect rates above the MY 2020 MMC Weighted Average.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid managed care.

MY 2020 Child CAHPS 5.1H Survey Results

Table 2.14: CAHPS MY 2020 Child Survey Results

Survey Section/Measure	2021 (MY 2020)	2021 Rate Compared to 2020	2020 (MY 2019)	2020 Rate Compared to 2019	2019 (MY 2018)	2021 MMC Weighted Average
Your Child's Health Plan						
Satisfaction with Child's Health Plan (Rating of 8–10)	88.42%	▼	89.75%	▲	89.21%	88.71%
Information or Help from Customer Service (Usually or Always)	86.54%	▼	89.39%	▲	82.95%	81.29%
Your Healthcare in the Last 6 Months						
Satisfaction with Health Care (Rating of 8–10)	89.74%	▲	87.50%	▲	86.74%	88.84%
Appointment for Routine Care When Needed (Usually or Always)	89.10%	▼	92.51%	▲	86.91%	84.77%

▲▼ = Performance increased (▲) or decreased (▼) compared to prior year's rate.
Gray shaded boxes reflect rates above the MY 2020 MMC Weighted Average.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid managed care.

III: Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

This section of the EQR report presents a review by IPRO of Geisinger Health Plan's (GEI'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 PA DHS within the past three years, most typically within the immediately preceding year.

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

Description of Data Obtained

The documents used by IPRO for the current review include the HealthChoices Agreement, the SMART database completed by PA DHS staff as of December 31, 2020, additional monitoring activities outlined by DHS staff, and the most recent NCQA Accreditation Survey for GEI effective in the review year.

The SMART items provided much of the information necessary for this review. The SMART items and their associated review findings for each year are maintained in a database. The SMART database has been maintained internally at DHS since Review Year (RY) 2013. Beginning in 2018 (RY 2017), there were changes implemented to the review process that impacted the data that are received annually. First, the only available review conclusions are Compliant and non-Compliant. All other options previously available were re-designated from review conclusion elements to review status elements and are therefore not included in the findings. Additionally, as noted, reviewers were given the option to review zones covered by an MCO separately, and to provide multiple findings within a year (e.g., quarterly). As a result, there was an increase in the number of partially compliant items for the initial year. For use in the current review, IPRO reviewed the data elements from each version of database and then merged the RY 2019, 2018, and 2017 findings. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 135 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 11 standards that CMS has designated as required to be subject to compliance review. Several previously required standards have been deemed by CMS as incorporated into the compliance review through interaction with the new required standards, and appear to assess items that are related to the required standards. The compliance evaluation was conducted on the crosswalked regulations for all 11 required standards and remaining related standards that were previously required and continue to be reviewed.

Table 3.1 provides a count of items linked to each category. Additionally, **Table 3.1** includes all regulations and standards from the three year review period (RY 2020, 2019, and 2018), which incorporates both the prior and the most recent set of EQR protocols. The CMS regulations are reflected in **Table 3.1** as follows: 1) a *Required* column has been included to indicate the 11 standards that CMS has designated as subject to compliance review, and 2) a *Related* column has been included to indicate standards that CMS has deemed as incorporated into the compliance review through interaction with the required standards.

Table 3.1: SMART Items Count per Regulation

BBA Regulation	SMART Items	Required	Related
Subpart C: Enrollee Rights and Protections			
Enrollee Rights	7		✓
Provider-Enrollee Communication	1		✓
Marketing Activities	2		✓
Liability for Payment	1		
Cost Sharing	0		
Emergency and Post-Stabilization Services – Definition	4		✓
Emergency Services: Coverage and Payment	1		✓
Solvency Standards	2		
Subpart D: MCO, PIHP and PAHP Standards			
Availability of Services	14	✓	
Assurances of adequate capacity and services	3	✓	
Coordination and Continuity of Care	13	✓	
Coverage and Authorization of Services	9	✓	
Provider Selection	4	✓	
Provider Discrimination Prohibited	1		✓
Confidentiality	1	✓	
Enrollment and Disenrollment	2		✓
Grievance and appeal Systems	1	✓	
Subcontractual Relationships and Delegations	3	✓	
Practice Guidelines	2	✓	
Health Information Systems	18	✓	
Subpart E: Quality Measurement and Improvement; External Quality Review			
Quality assessment and performance improvement program (QAPI)	9	✓	
Subpart F: Grievance and Appeal System			
General Requirements	8		✓
Notice of Action	3		✓
Handling of Grievances and Appeals	9		✓
Resolution and Notification	7		✓
Expedited Resolution	4		✓
Information to Providers and Subcontractors	1		✓
Recordkeeping and Recording	6		✓
Continuation of Benefits Pending Appeal and State Fair Hearings	2		✓
Effectuation of Reversed Resolutions	0		✓

Two previous categories, Cost Sharing and Effectuation of Reversed Resolutions, were not directly addressed by any of the SMART Items reviewed by DHS. Cost Sharing is addressed in the HealthChoices Agreement. Effectuation of Reversed Resolutions is evaluated as part of the most recent NCQA Accreditation review under Utilization Management (UM) Standard 8: Policies for Appeals and UM 9: Appropriate Handling of Appeals.

Review of Assurances of adequate capacity and services included three additional SMART Items that reference requirements related to provider agreements and reporting of appropriate services. Additionally, monitoring team review activities addressed other elements as applicable, including: readiness reviews of a new MCO's network against the requirements in the HealthChoices Agreement to ensure the ability to adequately serve the potential membership population; review of provider networks on several levels, such as annual MCO submissions of provider network, weekly submissions of provider additions/deletions together with executive summaries of gaps and plans of action to fill gaps as required, and regular monitoring of adequacy through review and approval of provider directories, access to care

campaigns and as needed; periodic review of provider terminations with potential to cause gaps in the MCO provider network, as well as review with the MCO of the provider termination process outlined in the HealthChoices Agreement.

Determination of Compliance

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 GEI, 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 GEI for the current review 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[1] to review the *Health Plan Report Cards 2021* for GEI. 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 fall 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.

Findings

Of the 135 SMART Items, 75 items were evaluated and 60 were not evaluated for the MCO in RY 2020, RY 2019, or RY 2018. For categories where items were not evaluated for compliance for RY 2020, results from reviews conducted within the two prior years (RY 2019 and RY 2018) were evaluated to determine compliance, if available.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this category is to ensure that each MCO had written policies regarding enrollee rights and complies with applicable Federal and State laws that pertain to enrollee rights, and that the MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. [42 C.F.R. §438.100 (a), (b)].

[1] NCQA *Health Plan Report Cards* Website: https://reportcards.ncqa.org/health-plans. Accessed January 25, 2022.

The SMART database and DHS's audit document information include assessment of the MCO's compliance with regulations found in Subpart C. **Table 3.2** presents the findings by categories consistent with the regulations. As indicated in **Table 3.1**, no regulation in this subpart is included in the updated required standards, although several are related standards.

Table 3.2: GEI Compliance with Enrollee Rights and Protections Regulations

ENROLLEE RIGHTS AND PROTECTIONS REGULATIONS		
Subpart C: Categories	**Compliance**	**Comments**
Enrollee Rights	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 6 items and was compliant on 6 items based on RY 2020.
Provider-Enrollee Communication	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Marketing Activities	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Cost Sharing	Compliant	Per HealthChoices Agreement
Emergency Services: Coverage and Payment	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Emergency and Post Stabilization Services	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2020.

MCO: managed care organization; RY: reporting year.

GEI was evaluated against 16 of the 18 SMART Items crosswalked to Enrollee Rights and Protections Regulations and was compliant on all 16 items. GEI was found to be compliant on all eight of the categories of Enrollee Rights and Protections Regulations. GEI was found to be compliant on the Cost Sharing provision, based on the HealthChoices Agreement.

Subpart D: MCO, PIHP and PAHP Standards

The general purpose of the regulations included under this heading is to ensure that all services available under the commonwealth's Medicaid managed care program are available and accessible to GEI enrollees. [42 C.F.R. §438.206 (a)].

The SMART database includes an assessment of the MCO's compliance with regulations found in Subpart D. For the category of Assurances of Adequate Capacity and Services, the MCO was evaluated as noted above against additional SMART Items and DHS monitoring activities. **Table 3.3** presents the findings by categories consistent with the regulations. Regulations that have been designated in **Table 3.1** as required under the updated protocols are **bolded**. The remaining are related standards.

Table 3.3: GEI Compliance with MCO, PIHP and PAHP Standards Regulations

MCO, PIHP AND PAHP STANDARDS REGULATIONS		
Subpart D: Categories	**Compliance**	**Comments**
Availability of Services	Compliant	14 items were crosswalked to this category. The MCO was evaluated against 10 items and was compliant on 10 items based on RY 2020.
Assurances of Adequate Capacity and Services	Compliant	3 items were crosswalked to this category. This category was evaluated against SMART Items and RY 2019 DHS monitoring activities.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 11 items and was compliant on 11 items based on RY 2020.

MCO, PIHP AND PAHP STANDARDS REGULATIONS		
Coverage and Authorization of Services	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 7 items and was compliant on 7 items based on RY 2020.
Provider Selection	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Provider Discrimination Prohibited	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Confidentiality	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Enrollment and Disenrollment	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Grievance and Appeal Systems	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Subcontractual Relationships and Delegations	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2020.
Practice Guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on 1 item based on RY 2020.
Health Information Systems	Compliant	18 items were crosswalked to this category. The MCO was evaluated against 11 items and was compliant on 11 items based on RY 2020.

MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan; RY: reporting year.

GEI was evaluated against 48 of 71 SMART Items that were crosswalked to MCO, PIHP and PAHP Standards Regulations and was compliant on 48 items. Of the 12 categories in MCO, PIHP and PAHP Standards, GEI was found to be compliant on 12 categories.

Subpart E: Quality Measurement and Improvement; External Quality Review

The general purpose of the regulations included under this heading is to ensure that managed care entities establish and implement an ongoing comprehensive QAPI program for the services it furnishes to its Medicaid enrollees. [42 C.F.R. §438.330].

The MCO's compliance with the regulation found in Subpart E was evaluated as noted above against additional SMART Items and DHS monitoring activities. **Table 3.4** presents the findings by categories consistent with the regulation. This regulation has been designated in **Table 3.1** as required under the updated protocols and is **bolded**.

Table 3.4: GEI Compliance with Quality Measurement and Improvement; External Quality Review Regulations

QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW REGULATIONS		
Subpart E: Categories	**Compliance**	**Comments**
Quality Assessment and Performance Improvement Program (QAPI)	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.

GEI was evaluated against one of the nine SMART Items crosswalked to Quality Assessment and Performance Improvement Program (QAPI) and was compliant on the one item.

Subpart F: Grievance and Appeal System

The general purpose of the regulations included under this heading is to ensure that enrollees have the ability to pursue grievances.

The SMART database and DHS's audit document information include assessment of the MCO's compliance with regulations found in Subpart F. **Table 3.5** presents the findings by categories consistent with the regulations. As indicated in **Table 3.1**, no regulation in this subpart is included in the updated required standards, although all are related standards.

Table 3.5: GEI Compliance with Grievance and Appeal System Regulations

GRIEVANCE AND APPEAL SYSTEM REGULATIONS		
Subpart F: Categories	**Compliance**	**Comments**
General Requirements	Compliant	8 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Notice of Action	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Handling of Grievances & Appeals	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Resolution and Notification	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Expedited Resolution	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Information to Providers and Subcontractors	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Recordkeeping and Recording	Compliant	6 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Continuation of Benefits Pending Appeal and State Fair Hearings	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Effectuation of Reversed Resolutions	Compliant	Per NCQA Accreditation, 2021. (See "Accreditation Status" below)

MCO: managed care organization; RY: reporting year; NCQA: National Committee for Quality Assurance.

GEI was evaluated against 13 of the 40 SMART Items crosswalked to Grievance and Appeal System and was compliant on all 13 items. GEI was found to be compliant for all nine categories of Grievance and Appeal System. For the category of Effectuation of Reversed Resolutions, per the NCQA website, the plan is Accredited. NCQA did not conduct surveys due to the COVID-19 pandemic.

Accreditation Status

GEI underwent an NCQA Accreditation Survey evaluation June 30, 2021 due to the ongoing COVID-19 pandemic which is effective through February 8, 2022. They were granted an Accreditation Status of Accredited.

IV: 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 4.1** displays the MCO's opportunities as well as IPRO's assessment of their responses. The detailed responses are included in the embedded Word document. 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 PH MCO has addressed the opportunities for improvement made by IPRO in the 2020 EQR Technical Reports, which were distributed May 2021. The 2021 EQR is the thirteenth to include descriptions of current and proposed interventions from each PH MCO that address the prior year reports' recommendations.

DHS requested that MCOs submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the MCOs. These activities follow a longitudinal format, and are designed to capture information relating to:

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

The documents informing the current report include the response submitted to IPRO as of September 2021, as well as any additional relevant documentation provided by GEI.

The embedded Word document presents GEI's responses to opportunities for improvement cited by IPRO in the 2020 EQR Technical Report, detailing current and proposed interventions.

GEI 2020 Opps Response Request F

Root Cause Analysis and Action Plan

The 2021 EQR is the twelfth year MCOs were required to prepare a Root Cause Analysis and Action Plan for measures on the HEDIS MY 2020 P4P Measure Matrix receiving either "D" or "F" ratings. Each P4P measure in categories "D" and "F" required that the MCO submit:

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

GEI submitted an initial Root Cause Analysis and Action Plan in September 2021. For each measure in grade categories D and F, GEI completed the embedded form, identifying factors contributing to poor performance.

GEI 2020 Root Cause Analysis Resp

For the 2021 EQR, GEI was required to prepare a Root Cause Analysis and Action Plan for the following performance measures:

- Annual Dental Visit (Ages 2—20 years).

GEI Response to Previous EQR Recommendations

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

Table 1: GEI Response to Previous EQR Recommendations

Recommendation for GEI	IPRO Assessment of MCO Response[1]
Improve Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase	Addressed
Improve Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase	Addressed
Improve Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase	Addressed
Improve Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase	Addressed
Improve Annual Dental Visit (Age 2–20 years)	Remains an opportunity for improvement
Improve Annual Dental Visits for Members with Developmental Disabilities (Age 2-20years)	Remains an opportunity for improvement
Improve Dental Sealants for 6-9 Year Old Children At Elevated Caries Risk	Measure retired
Improve Chlamydia Screening in Women (Total)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Age 16-20 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Age 21-24 years)	Remains an opportunity for improvement
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20)	Partially addressed
Improve Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)	Remains an opportunity for improvement
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 21 to 44)	Addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21 to 44)	Partially addressed
Improve Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44)	Remains an opportunity for improvement
Improve Cesarean Rate for Nulliparous Singleton Vertex	Measure retired
Improve Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	Addressed
Improve Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000	Partially

Recommendation for GEI	IPRO Assessment of MCO Response[1]
member months	addressed
Improve Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months	Partially addressed
Improve Use of Opioids From Multiple Providers (4 or more prescribers)	Addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: either of the following (1) improvement was observed, but identified as an opportunity for current year; or (2) improvement not observed, but not identified as an opportunity for current year; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed or performance declined.

EQR: external quality review; MCO: managed care organization.

V: MCO Strengths and Opportunities for Improvement and EQR Recommendations

The review of the MCO's MY 2020 performance for all EQR activities conducted, against Medicaid and CHIP managed care regulations, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for Medicaid members served by this MCO. The strengths and opportunities listed below are also outlined within each applicable section above. Each section contains more detail regarding the review and identification of the items.

Strengths

- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2021 (MY 2020) on the following measures:
    - Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years);
    - Adults' Access to Preventive/Ambulatory Health Services (Age 45-64 years);
    - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years);
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11);
    - Well-Child Visits in the First 30 Months of Life (15-30 months ≥ 2 Visits);
    - Child and Adolescent Well-Care Visits (12-17 years);
    - Body Mass Index: Percentile (Age 3 - 11 years);
    - Body Mass Index: Percentile (Age 12-17 years);
    - Body Mass Index: Percentile (Total);
    - Counseling for Physical Activity (Age 3-11 years);
    - Counseling for Physical Activity (Total);
    - Lead Screening in Children (Age 2 years);
    - Developmental Screening in the First Three Years of Life – Total;
    - Developmental Screening in the First Three Years of Life – 1 year;
    - Developmental Screening in the First Three Years of Life – 2 years;
    - Developmental Screening in the First Three Years of Life – 3 years;
    - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days);
    - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days);
    - Sealant Receipt on Permanent First Molars (≥ 1 Molar);
    - Sealant Receipt on Permanent First Molars (All 4 Molars);
    - Breast Cancer Screening (Age 50-74 years);
    - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20);
    - Prenatal Screening for Smoking;
    - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator);
    - Prenatal Screening for Environmental Tobacco Smoke Exposure;
    - Prenatal Screening for Depression;
    - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator);
    - Prenatal Screening Positive for Depression;
    - Postpartum Screening Positive for Depression;
    - Appropriate Testing for Pharyngitis (Age 18-64 years);
    - Asthma Medication Ratio (5-11 years);
    - Asthma Medication Ratio (12-18 years);
    - Asthma in Younger Adults Admission Rate (Age 2-17 years) per 100,000 member months;
    - Asthma in Younger Adults Admission Rate (Total Age 2-39 years) per 100,000 member months;
    - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months;
    - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months;

- Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months;
- HbA1c Poor Control (>9.0%);
- Retinal Eye Exam;
- Blood Pressure Controlled <140/90 mm Hg;
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age);
- Controlling High Blood Pressure (Total Rate);
- Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months;
- Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months;
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Age 12-17 years);
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Age 1-17 years);
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Age 1-17 years);
- Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine); and
- Use of Pharmacotherapy for Opioid Use Disorder (Long-Acting, Injectable Naltrexone).

- GEI was found to be fully compliant on all contract and with state and federal managed care regulations reviewed.

Opportunities for Improvement

- GEI was found to be partially compliant on four of five review elements for both Opioid and Readmissions PIP. GEI was non-compliant on one item for both PIPs: Element 5. Discussion.

- The MCO's performance was statistically significantly below/worse than the MMC rate in 2021 (MY 2020) as indicated by the following measures:
  - Annual Dental Visit (Age 2–20 years);
  - Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years);
  - Adult Annual Dental Visit ≥ 21 Years (Age 65 years and older);
  - Adult Annual Dental Visit Women with a Live Birth (Age 36-59 years);
  - Chlamydia Screening in Women (Total);
  - Chlamydia Screening in Women (Age 16-20 years);
  - Chlamydia Screening in Women (Age 21-24 years);
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20);
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20);
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21 to 44);
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44);
  - Prenatal Smoking Cessation;
  - Appropriate Treatment for Upper Respiratory Infection (Age 3 months-17 years);
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Age 3 months-17 years);
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total);
  - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months;
  - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months; and
  - Use of Pharmacotherapy for Opioid Use Disorder (Total).

Additional targeted opportunities for improvement are found in the MCO-specific HEDIS MY 2020 P4P Measure Matrix that follows.

P4P Measure Matrix Report Card 2021 (MY 2020)

The Pay-for-Performance (P4P) Matrix Report Card provides a comparative look at all measures in the Quality Performance Measures component of the "HealthChoices MCO Pay for Performance Program." There are ten measures: seven are classified as both HEDIS and CMS Core Set measures, two are solely HEDIS and one is solely a CMS Child Core Set measure. The matrix:

1. Compares the Managed Care Organization's (MCO's) own P4P measure performance over the two most recent reporting years (2021 (MY 2020) and 2020 (MY 2019)); and
2. Compares the MCO's MY 2020 P4P measure rates to the MY 2020 Medicaid Managed Care (MMC) Weighted Average, or the MCO Average as applicable.

A matrix represents the comparisons in each of **Figure 5.1** and **Figure 5.2**. In **Figure 5.1**, the horizontal comparison represents the MCO's current performance as compared to the most recent MMC weighted average. When comparing a MCO's rate to the MMC weighted average for each respective measure, the MCO rate can be either above average, average, or below average. For each rate, the MCO's performance is determined using a 95% confidence interval for that rate. The difference between the MCO rate and MMC Weighted Average is statistically significant if the MMC Weighted Average is not included in the range, given by the 95% confidence interval. When noted, the MCO comparative differences represent statistically significant differences from the MMC weighted average.

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, or trend down (⇩). For these year-to-year comparisons, the statistical 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 study populations. Noted comparative differences denote statistically significant differences between the years.

Figure 5.2 represents a matrix for the Plan All-Cause Readmissions measure. Instead of a percentage, performance on this measure is assessed via a ratio of observed readmissions to expected readmissions. Additionally, a MMC Weighted Average is not calculated. Given the different parameters for this measure, comparisons are made based on absolute differences in the O/E ratio between years and against the current year's MCO Average.

For some measures, lower rates indicate better performance; these measures are specified in each matrix. Therefore, the matrix labels denote changes as above/better and below/worse. Each matrix is color-coded to indicate when a MCO's performance for these P4P measures is notable or whether there is cause for action. Using the comparisons described above as applicable for each measure, the color codes are:

The green box (A) indicates that performance is notable. The MCO's MY 2020 rate is above/better than the MY 2020 average and above/better than the MCO's MY 2019 rate.

The light green boxes (B) indicate either that the MCO's MY 2020 rate does not differ from the MY 2020 average and is above/better than MY 2019, or that the MCO's MY 2020 rate is above/better than the MY 2020 average but there is no change from the MCO's MY 2019 rate.

The yellow boxes (C) indicate that the MCO's MY 2020 rate is below/worse than the MY 2020 average and is above/better than the MY 2019 rate, or the MCO's MY 2020 rate does not differ from the MY 2020 average and there is no change from MY 2019, or the MCO's MY 2020 rate is above/better than the MY 2020 average but is lower/worse than the MCO's MY 2019 rate. No action is required although MCOs should identify continued opportunities for improvement.

The orange boxes (D) indicate either that the MCO's MY 2020 rate is lower/worse than the MY 2020 average and there is no change from MY 2019, or that the MCO's MY 2020 rate is not different than the MY 2020 average and is lower/worse than the MCO's MY 2019 rate. ***A root cause analysis and plan of action is therefore required.***

The red box (F) indicates that the MCO's MY 2020 rate is below/worse than the MY 2020 average and is below/worse than the MCO's MY 2019 rate. ***A root cause analysis and plan of action is therefore required.***

GEI Key Points

▪ A - Performance is notable. No action required. MCOs may have internal goals to improve.

Measure(s) that in MY 2020 are statistically significantly above/better than the MY 2020 MMC weighted average and statistically significantly above/better than the MCO's MY 2019 rate:

- Lead Screening in Children

Measure(s) that in MY 2020 are above/better than the MY 2020 average and above/better than the MCO's MY 2019 rate:

- Plan All-Cause Readmissions[2]

▪ B - No action required. MCOs may identify continued opportunities for improvement.

Measure(s) that in MY 2020 are statistically significantly above/better than the MY 2020 MMC weighted average but not statistically significantly different from the MCO's MY 2019 rate:

- Comprehensive Diabetes Care: HbA1c Poor Control[3]
- Controlling High Blood Pressure

▪ C - No action required although MCOs should identify continued opportunities for improvement.

Measure(s) that in MY 2020 did not statistically significantly change from MY 2019, and are not statistically significantly different from the MY 2020 MMC weighted average:

- Prenatal Care in the First Trimester
- Postpartum Care
- Asthma Medication Ratio[4]

Measure(s) that in MY 2020 statistically significantly above/better than the MY 2020 MMC weighted average, but are statistically significantly lower/worse than the MCO's MY 2019 rate:

- Developmental Screening in the First Three Years of Life

▪ D - Root cause analysis and plan of action required.

Measure(s) that in MY 2020 are not statistically significantly different than the MY 2020 MMC weighted average, but are statistically significantly lower/worse than the MCO's MY 2019 rate:

- Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[5]

▪ F - Root cause analysis and plan of action required.

Measure(s) that in MY 2020 are statistically significantly lower/worse than MY 2019, and are statistically significantly lower/worse than the MY 2020 MMC weighted average:

- Annual Dental Visit (Ages 2—20 years)

[2] Plan All-Cause Readmissions was added as a P4P measure in 2021 (MY 2020). Lower rates indicate better performance.
[3] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.
[4] Asthma Medication Ratio was added as a P4P measure in 2021 (MY 2020) to replace Medication Management of Asthma.
[5] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaces Well-Child Visits in the First 15 Months of Life, 6 or more.

Figure 5.1: P4P Measure Matrix – Rate Measures

Year to Year Statistical Significance Comparison	Trend	Medicaid Managed Care Weighted Average Statistical Significance Comparison: Below/Worse than Average	Average	Above/Better than Average
	↑	**C**	**B**	**A** Lead Screening in Children
	No Change	**D**	**C** Prenatal Care in the First Trimester; Postpartum Care; Asthma Medication Ratio[6]	**B** Comprehensive Diabetes Care: HbA1c Poor Control[7]; Controlling High Blood Pressure
	↓	**F** Annual Dental Visit (Ages 2—20 years)	**D** Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[8]	**C** Developmental Screening in the First Three Years of Life

Figure 5.2: P4P Measure Matrix – PCR Ratio Measure

	Trend	MCO Average Comparison: Below/Worse than Average	Average	Above/Better than Average
Year to Year	↑	**C**	**B**	**A** **Plan All-Cause Readmissions[9]**

[6] Asthma Medication Ratio was added as a P4P measure in 2021 (MY 2020) to replace Medication Management of Asthma.
[7] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.
[8] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaces Well-Child Visits in the First 15 Months of Life, 6 or more.
[9] Plan All-Cause Readmissions was added as a P4P measure in 2021 (MY 2020). Lower rates indicate better performance.

P4P performance measure rates for 2018 (MY 2017), 2019 (MY 2018), 2020 (MY 2019), and MY 2020 as applicable are displayed in **Table 5.1**. The following symbols indicate the differences between the reporting years.

- ▲ Statistically significantly higher than the prior year,
- ▼ Statistically significantly lower than the prior year or
- = No change from the prior year.

Table 5.1: P4P Measure Rates

Quality Performance Measure – HEDIS Percentage Rate Metric[1]	HEDIS 2018 (MY 2017) Rate	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 MMC WA
Comprehensive Diabetes Care - HbA1c Poor Control[2]	32.3% =	29.1% =	29.1% =	33.6% =	38.4%
Controlling High Blood Pressure	70.5% =	71.8% =	71.8% =	71.5% =	63.4%
Prenatal Care in the First Trimester	86.6% =	85.2% =	91.7% ▲	88.3% =	88.9%
Postpartum Care	70.3% =	68.6% =	82.0% ▲	77.4% =	77.8%
Annual Dental Visits (Ages 2 – 20 years)	57.8% =	58.5% ▲	54.4% ▼	45.7% ▼	54.2%
Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[3]	74.9% =	74.1% =	74.1% =	66.4% ▼	65.2%
Asthma Medication Ratio[4]				65.5% =	64.8%
Lead Screening in Children			82.2% =	88.3% ▲	83.2%
Quality Performance Measure – Other Percentage Rate Metric	**2018 (MY 2017) Rate**	**2019 (MY 2018) Rate**	**2020 (MY 2019) Rate**	**MY 2020 Rate**	**MY 2020 MMC WA**
Developmental Screening in the First Three Years of Life (CMS Child Core)			65.4% ▲	63.9% ▼	59.6%
Quality Performance Measure – HEDIS Ratio Metric	**HEDIS 2018 (MY 2017) Ratio**	**HEDIS 2019 (MY 2018) Ratio**	**HEDIS 2020 (MY 2019) Ratio**	**HEDIS MY 2020 Ratio**	**HEDIS MY 2020 MCO Average**
Plan All-Cause Readmissions[5]				0.78 ▼	1.02

[1] Statistically significant difference is indicated for all measures except Plan All-Cause Readmissions. For this measure, differences are indicated based on absolute differences in the O/E ratio between years.
[2] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.
[3] Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaces Well-Child Visits in the First 15 Months of Life, 6 or more.
[4] Asthma Medication Ratio was added as a P4P measure in 2021 (MY 2020) to replace Medication Management of Asthma.
[5] Plan All-Cause Readmissions was added as a P4P measure in 2021 (MY 2020). Lower rates indicate better performance.
P4P: Pay-for-Performance; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; MMC: Medicaid Managed Care; WA: weighted average.

Table 5.2: EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It is recommended that the MCO review guidance provided during the Proposal period regarding the inclusion of MCO baseline rates in discussion around why this project topic is an area of opportunity for GEI.	Quality
	It is recommended that that amount of improvement sought for this project, along with the interventions that will be used to achieve this improvement, be stated clearly in the report.	Quality
	It was recommended that GEI utilize formal root cause analyses such as the 5 Whys and other modalities to determine underlying causes of their barriers.	Quality
	It was recommended that the MCO implement the specific guidance provided regarding their selected ITMs, including adding definitions for all and ensuring there is an ITM for each intervention that was developed.	Quality
	Regarding the data provided in the Results section, it was recommended that an explanation be included as to why the baseline data for Indicator 6 could not be validated.	Quality
	It was recommended that GEI complete the Discussion section of the Interim Report in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It is strongly recommended that GEI use the guidance provided during Proposal review in conjunction with the example AIMs statement provided within the PIP template to completely revise the AIMs and Objectives section.	Quality
	Regarding target rates, it is recommended that the MCO calculate out all target rates based upon the baseline period data provided.	Quality
	It is recommended that the project timeline be updated to reflect specific start dates for better tracking throughout the lifetime of the PIP.	Timeliness
	It is recommended that the MCO consider determining if medication adherence is a true barrier in this population and designating ITM 3c as a separate and independent intervention.	Quality
	It is recommended that GEI complete the Discussion section of the Interim Report in order to interpret the extent to which the PIP has been successful thus far, along with identifying any limitations that may threaten internal or external validity.	Quality
Performance Measures and CAHPS Survey		
Annual Dental Visits	It is recommended that GEI improve access to annual dental visits for its members. The measures Annual Dental Visit (Age 2–20 years) and Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years) were both opportunities in 2020 and again in 2021. Both measures have reported rates that decreased in 2021.	Access
Women's Health Screenings	It is recommended that the MCO improve screening access for their members, particular around women's health. The measure Chlamydia Screening in Women was an opportunity in 2020 for all age cohorts, and was identified as an opportunity again in 2021.	Access
Access to Contraceptive Care	It is recommended that GEI improve access to contraceptive care for postpartum women. The Contraceptive Care for Postpartum Women: LARC - 60 days measure for ages 15 to 20 and 21 to 44 decreased in 2021, and were opportunities in 2020 and 2021.	Access

VI: Summary of Activities

Performance Improvement Projects

- As previously noted, GEI's Opioid and Readmission PIP proposal submissions were validated. The MCO received feedback and subsequent information related to these activities from IPRO.

Performance Measures

- GEI reported all HEDIS, PA-Specific, and CAHPS Survey performance measures in 2021 for which the MCO had a sufficient denominator.

Structure and Operations Standards

- GEI was found to be fully compliant on all contract and with state and federal managed care regulations reviewed. Compliance review findings for GEI from RY 2021, RY 2020, and RY 2019 were used to make the determinations.

2020 Opportunities for Improvement MCO Response

- GEI provided a response to the opportunities for improvement issued in the 2020 annual technical report and a root cause analysis and action plan for those measures on the HEDIS 2020 P4P Measure Matrix receiving either "D" or "F" ratings.

2021 Strengths and Opportunities for Improvement

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

Appendix

Performance Improvement Project Interventions

As referenced in **Section I: Validation of Performance Improvement Projects**, **Table A.1.1** lists all of the interventions outlined in the MCO's most recent PIP submission for the review year.

Table A.1.1: PIP Interventions

Summary of Interventions
Geisinger Health Plan – Opioid
1. Pharmacy and Medical Director review weekly members who fill a prescription for an opioid and then later fill a prescription for suboxone. The pharmacists and medical director assess the appropriateness of therapy. Medical director outreach is made if potentially inappropriate prescribing practices or trends are identified.
2. Case Management (addiction Coordinator) referral for outreach to members following an ED visit with an OUD diagnosis. Additionally, we have Certified Recovery Specialists available to meet with members at the ED if needed.
3. Work with one of the local opioid coalitions to develop a pilot program to coordinate a continuum of care, including, but not limited to treatment resources, naloxone distribution, and social determinants to improve and sustain long-term recovery for individuals with opiate use disorder.
Geisinger Health Plan – Readmission
1a. Automated referral to Community Health Assistants for member outreach triggered by an ED visit with a LANE (low acuity non emergent) diagnosis who have had 3 or more ED visits in the last 6 months. Member education, home, and community visits, assisting members with connecting to primary and specialty care. Address SDOH needs. Escalate to other members of the care team as indicated. The CHAs are providing additional education on accessing appropriate care at the ED/Urgent Care/PCP. Evaluating barriers to accessing appropriate care and assisting members with accessing resources to overcome these barriers to care. The CHAs are escalating members to the additional Care team members such as RN Case Managers or Behavioral Health Case Managers for additional clinical intervention. In 2020 GHP Care Management screened approximately 2,300 members for SDOH needs. Over 500 members indicated difficulty with affording food, housing, and transportation. 1b. Referral to Behavioral Health Care Management team for members with 2 or more ED visits in the last 6 months with a primary mental health or substance use disorder diagnosis.
2a. Transportation program primarily managed by the Community Health Assistants who assist members with linkage to reliable transportation resources.
3a. Escalation of complex and high-risk membership to Geisinger @ Home to allow for those in the rising risk population to be enrolled in a Care Management program or to be connected with a care team member. Any member discharging from Geisinger Hospitals with a complex risk score, identified as home bound with complex needs, members identified with clinical management issues resulting in increased and/or inappropriate utilization are referred to G@H for ongoing management. Geisinger @ Home provides in home services by a provider and interdisciplinary care team. These services include, but are not limited to checkups, routine testing, wound care, respiratory care, nutritional needs, urgent and specialty care. We will monitor the volume of referrals to G@H and actual enrollment. We will monitor and review overall utilization for this population. 3b. Referral to Behavioral Health Care Management team for members with a psychiatric admission for transition of care with a primary mental health or substance use disorder diagnosis.

Summary of Interventions
3c. Adherence to antipsychotic medications for Individuals with Schizophrenia (SAA HEDIS Measure) – GHP pharmacy sends letters to members 18 years of age and older with Schizophrenia or Schizoaffective disorder who were dispensed an antipsychotic medication and have a PDC (proportion of days covered) less than 80% to notify them that they are non-adherent to one or more antipsychotic medication(s) and remind them to refill if appropriate.
4a. Pilot and provide and Interactive Voice Response (IVR) program for moderate to low-risk members following hospital discharge. These are the members who do not meet the criteria for complex care management or Geisinger @ Home intervention. GHP will monitor the volume identified for the program, volume engaged, and volume of triggers/alerts for CM follow up.
5a. Alerts to the Behavioral Health Care Management team for those members enrolled who are identified with an initial Substance Use disorder diagnosis. 5b. Referral to Addiction Coordinators on the Behavioral Health Care Management team for members identified for SUD dx (HEDIS IET).

PIP: performance improvement project.