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

2022 External Quality Review Report
Geisinger Health Plan

Final Report
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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 an 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 Children's Health Insurance Program (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 2022 EQRs (Review Period: 1/1/2021–12/31/2021) 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 *Title 42 Code of Federal Regulations (CFR) Section (§) 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 (RY), 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. Validation of Performance Improvement Projects
II. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey
III. Review of Compliance with Medicaid and CHIP Managed Care Regulations
IV. MCO Responses to the Previous EQR Recommendations
V. Strengths, Opportunities for Improvement, and EQR Recommendations
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 Medicaid and CHIP Managed Care Regulations 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 includes the MCO's responses to the 2021 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 MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

In accordance with current BBA regulations, 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 focus studies each year. For all PH MCOs, two PIPs were initiated as part of this requirement in 2020. For each PIP, 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 number 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 reducing stigma. 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. This 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 (P4P) Program, which was implemented in 2016 to address the needs of individuals with severe and 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 behavioral health (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 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, 2022, 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 quality improvement organizations (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. 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'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's enrollment and generalizable to the MCO'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 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. Measurement years (MYs) 2019 and 2020 were the baseline year and proposal year. MY 2021 was the first interim review year, and elements were reviewed and scored at multiple points during the year once interim reports were submitted. All MCOs received some level of guidance towards improving their projects in these findings, and MCOs responded accordingly with resubmission to correct specific areas. MY 2022 was the second interim review year, and elements were reviewed and scored once interim reports were submitted in October 2022. These initial review findings are included in each MCO's technical report, although MCOs continue to respond and resubmit as applicable 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**
Met	Met or exceeded the element requirements	100%
Partially Met	Met essential requirements but is deficient in some areas	50%
Not Met	Has not met the essential requirements of the element	0%

When the PIPs are reviewed, all projects are evaluated 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 2022, the third year of the cycle, there were several levels of communication provided to MCOs after their first interim submissions and in preparation for their second Interim submissions, including:

- MCO-specific review findings for each PIP, including detailed information to assist MCOs in preparing their next 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 review 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, 2022, MCOs were requested to submit a Project Interim Report, including updated rates and interventions. 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 resubmissions, GEI provided information regarding membership but did not add the MCO prevalence or treatment data in subsequent submissions, so this remains an unaddressed recommendation.

GEI provided aims and objectives statements in which they described the interventions they plan to implement and how the interventions will improve rates for the performance indicators. However, the MCO was advised they 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, Percentage of Individuals with OUD who receive MAT, and Performance Indicator 6, Use of Pharmacotherapy for Opioid Use Disorder. Additionally, the intervention regarding opioid coalitions was 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 resubmissions.

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 did 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 was 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 was advised to 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 referenced 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 was instructed to 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 but was addressed in a subsequent resubmission. Once the updates were 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 was 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 2021 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.

In October 2022, the MCO submitted a second Interim report for this project. Reviewers noted that several previous recommendations were not addressed. As noted above, these suggestions included comparison of baseline MCO rates to national or state benchmarks and addressing each performance indicator by stating the amount of improvement sought, and the interventions that will be used to achieve this improvement. The plan was strongly encouraged to carefully review the recommendations given and to use the PIP template as a direct guide for the appropriate development of this PIP. Reviewers also observed that the barriers continued to include outcomes, not barriers, specifically in Barrier 2, which is identified as "ED utilization for Opioid Use." Reviewers also indicated that there were only three barriers listed and that it remains unclear if additional analysis went into these barriers. Reviewers recommended that the plan obtain direct member or provider feedback to identify barriers. Regarding ITMs, ITMs 2b and 3b remained blank. Reviewers encouraged the plan to review the previous recommendations, noting again that interventions and their corresponding ITMs required additional information, including descriptions for all numerators and denominators for ITMs, 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. Additionally, ITMs 2a, 2b, and 3a showed no data since Q3 2021.

Regarding results, the plan did reformat Indicators 2 and 3 as requested to separate numerators. Interim results were provided for five of the seven measures, with improvement shown in three. However, interim results were not provided for two measures, and the previously requested explanation regarding baseline rates had not been provided, therefore it is difficult to evaluate if improvements are as observed. As with the previous interim submission and resubmissions and although required in the template, no Discussion section was included in GEI's second Interim Report. Recommendations were provided to the plan in light of these Interim findings, as noted below. **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 second Interim Report review process:

- It was again recommended that the MCO review guidance previously provided during the Proposal and Interim periods regarding the MCO baseline rates and discussion around why this project topic is an area of opportunity for GEI, including examining plan-specific data and rates for opportunities for improvement and ways to address disparities.
- Previously, 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. The plan was strongly encouraged to carefully review the previous recommendations given and to use the PIP template as a direct guide for the appropriate development of this PIP.
- It was previously recommended that GEI utilize formal root cause analyses such as the 5 Whys and other modalities to determine underlying causes of their barriers. Related to this, it was recommended that the plan obtain direct member or provider feedback to identify barriers.
- It was again 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.
- It was again recommended that GEI complete the Discussion section, currently for the second Interim Report. This is 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.
- It was recommended that the plan update descriptions of changes to the project within the applicable sections of the PIP document as noted in the findings.

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, the plan was advised to

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 has not been 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 were 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 a 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, was missing the baseline rate. Likewise, Performance Indicator 8, Inpatient 30-Day Readmission Rate for Individuals with SPMI, was 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, had rationales for their target rates that referenced the Quality Compass. It was recommended that the MCO clarify if the target rates are referencing the HEDIS 2020 (MY 2019) Quality Compass year. In addition, the MCO was advised that percentiles should be specified in the target rate rationales for Performance Indicators 1 and 4.

In the PIP, the MCO was advised that they 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. It was 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, it was recommended that Performance Indicator 2 should be revised to reflect total member months as well. The MCO was advised to also define the SPMI criteria for the applicable measures, as referenced in the PIP baseline review. For Indicator 4, the plan was advised that for both Initiation and Engagement, the numerator should state the number (not percentage) and it was recommended that the denominator be comprised of members with a new diagnosis of AOD abuse or dependence (rather than all adolescent and adult continuously enrolled members). The MCO was informed that 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 consisted of four member interventions and no provider interventions. It was 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 MCO was instructed that 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 was recommended that GEI include item descriptions above the numerators, denominators, and rates for all ITMs.

Lastly, when correcting the baseline and target rates as indicated, the MCO was recommended to 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 were 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.

In October 2022, the MCO submitted a second Interim report for this project. Reviewers noted that several previous recommendations were not addressed. Previously, the plan was advised to 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. No additional information was provided by the plan. The plan was also previously advised to ensure that each performance indicator is addressed by a statement of aims and objectives and that all indicators, including those referencing members with SPMI, be addressed. The plan added aims and objective statements but again did not frame them with descriptions of how the interventions will improve rates for the performance indicators.

As noted previously, there are no provider interventions included in the project. In addition, the above observation regarding ITM 3c remained unaddressed. Additionally, there were missing descriptions and/or data for the following ITMs: 1b, 2b, 4a, 4b, and 5a. Reviewers noted that intervention planned and actual start dates were not included as previously recommended, therefore, it is difficult to determine if/when interventions were enhanced. Overall, inconsistent ITMs, associated interventions and rates again made interpretation of ITMs difficult.

Regarding results, interim results were provided in the Results table for only four of the eight measures. Additionally, the data provided in Tables 2 and 6 did not match and some previous items were not addressed, therefore it is not possible to determine if improvements were achieved. As with the previous interim submission and resubmissions and although required in the template, no Discussion section was included in GEI's Second Interim Report. Recommendations were provided to the plan in light of these Interim findings, as noted below. **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 again strongly recommended that GEI use the guidance provided during Proposal and Interim reviews in conjunction with the example aim statement provided within the PIP template to revise the aims and objectives section as indicated.
- The plan was strongly encouraged to carefully review the previous recommendations given and to use the PIP template as a direct guide for the appropriate development of this PIP. Related to this, it was recommended that the plan address the recommendations for Indicator 4, including delineation of Initiation and Engagement measures within table 3.
- It was again recommended that the project timeline be updated to reflect specific start dates for better tracking throughout the lifetime of the PIP.

- It was previously 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. This was not addressed and remains a recommendation.
- It was again recommended that GEI complete the Discussion section, currently for the second Interim Report. This is 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.
- It was recommended that the plan fully populate Implementation Period and Interim Submission dates within the applicable sections of the PIP document as noted in the findings.

GEI's Second Interim Report 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	Partially Met	Partially Met
2. Methodology	Met	Partially Met
3. Barrier Analysis, Interventions and Monitoring	Partially Met	Partially Met
4. Results	Partially Met	Partially Met
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; N/A: not applicable.

II: Performance Measures and CAHPS Survey

Objectives

IPRO validated Adult and Child Core Set and PA-specific performance measures, as well as HEDIS data for each of the Medicaid PH MCOs.

The MCOs were provided with final specifications for the PA Performance Measures from February 2022 to July 2022. Source code, raw data, and rate sheets were submitted by the MCOs to IPRO for review in 2022. 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.

HEDIS MY 2021 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 2021, audit activities continued to be 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 to/Availability of 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 years)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17 years)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total Ages 1 to 17 years)
Well-Care Visits and Immunizations	
HEDIS	Well-Child Visits in the First 30 Months of Life (Ages 15 months ≥ 6 Visits)
HEDIS	Well-Child Visits in the First 30 Months of Life (Ages 15 to 30 months ≥ 2 visits)
HEDIS	Child and Adolescent Well-Care Visits (Ages 3 to 11 years)
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 3)
HEDIS	Childhood Immunizations Status (Combination 7)
HEDIS	Childhood Immunizations Status (Combination 10)

Source	Measures
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 (Age 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
Behavioral Health	
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages 18 to 64 years—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 years—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 years—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 years—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 years and older—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 65 years 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 years and older—ED visits for mental illness, follow-up within 7 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages 65 years and older—ED visits for mental illness, follow-up within 30 days)

Source	Measures
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)
PA EQR	Oral Evaluation, Dental Services (Ages < 1–20 years)
PA EQR	Topical Fluoride for Children (Dental/Oral Health Services)
PA EQR	Topical Fluoride for Children (Dental Services)
PA EQR	Topical Fluoride for Children (Oral Health Services)
Women's Health	
HEDIS	Breast Cancer Screening (Ages 50–74 years)
HEDIS	Cervical Cancer Screening (Ages 21–64 years)
HEDIS	Chlamydia Screening in Women (Ages 16–20 years)
HEDIS	Chlamydia Screening in Women (Ages 21–24 years)
HEDIS	Chlamydia Screening in Women (Total)
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 years)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20 years)
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44 years)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44 years)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 15 to 20 years)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 15 to 20 years)
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 15 to 20 years)
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 15 to 20 years)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 21 to 44 years)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 21 to 44 years)
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 21 to 44 years)
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 21 to 44 years)
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)

Source	Measures
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS)
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 (Ages 5–11 years)
HEDIS	Asthma Medication Ratio (Ages 12–18 years)
HEDIS	Asthma Medication Ratio (Ages 19–50 years)
HEDIS	Asthma Medication Ratio (Ages 51–64 years)
HEDIS	Asthma Medication Ratio (Total)
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 2–17 years)—Admissions per 100,000 member months
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 18–39 years)—Admissions per 100,000 member months
PA EQR	Asthma in Children and Younger Adults Admission Rate (Total Ages 2–39 years)—Admissions per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years)—Admissions per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older)—Admissions per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total 40+ years)—Admissions per 100,000 member months
Comprehensive Diabetes Care	

Source	Measures
HEDIS	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
HEDIS	Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)
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)—Admissions per 100,000 member months
PA EQR	Diabetes Short-Term Complications Admission Rate (Ages 65+ years)—Admissions per 100,000 member months
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years)—Admissions 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 Age)
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Ages Cohort: 65–75 Years of Age)
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Ages Cohort: 18–75 Years of Age)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 18–64 years)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 65–74 years)
HEDIS	Kidney Health Evaluation for Patients With Diabetes (Ages 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)—Admissions per 100,000 member months
PA EQR	Heart Failure Admission Rate (Ages 65+ years)—Admissions per 100,000 member months
PA EQR	Heart Failure Admission Rate (Total Ages 18+ years)—Admissions per 100,000 member months
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Ages 21–75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Ages 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% Ages 21–75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% Ages 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 ages 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 ages 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 ages 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 ages 18 years and older)
Utilization	

Source	Measures
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)
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. 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 2022 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 2022 (MY 2021), 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. Three age groups are reported: ages 1–11 years, ages 12–17 years, and total ages 1–17 years.

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 MY 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 years and 65 years 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 years and 65 years and older.

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

Sealant Receipt on Permanent First Molars—CHIPRA Core Set
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 Years—CMS Core Measure
This performance measure assesses the percentage of women ages 15 to 44 years 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 years and 21–44 years): 1) provision of most or moderately effective contraception, and 2) provision of LARC.

Contraceptive Care for Postpartum Women Ages 15–44 Years—CMS Core Measure
This performance measure assesses the percentage of women ages 15 to 44 years 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 years and 21–44 years): 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, ages 65 years and older, and ages 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, ages 65 years and older, and ages 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. Two age groups are reported: ages 18–64 years and ages 64–75 years, as well as a total rate.

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 ages 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, ages 65 years and older, and ages 18+ years.

Use of Pharmacotherapy for Opioid Use Disorder—Adult Core Set
This performance measure assesses the percentage of members ages 18 to 64 years 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.

Oral Evaluation, Dental Services—Child Core Set—New for 2022
This performance measure assesses the percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the measurement year. Nine age groups are collected: ages < 1 year, ages 1–2 years, ages 3–5 years, ages 6–7 years, ages 8–9 years, ages 10–11 years, ages 12–14 years, ages 15–18 years, and ages 19–20 years. Only the total, ages < 1–20 years old, is reported in this publication.

Topical Fluoride for Children—Child Core Set—New for 2022
This performance measure assesses the percentage of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as: 1) dental or oral health services, 2) dental services, and 3) oral health services within the measurement year. MCO rates will be reported as identified by the MCO. Eight age groups are collected: ages 1–2 years, ages 3–5 years, ages 6–7 years, ages 8–9 years, ages 10–11 years, ages 12–14 years, ages 15–18 years, and ages 19–20 years. Only the total, ages 1–20 years old, is reported in this publication.

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 for members 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 2021 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 2021 Prenatal and Postpartum Care Measure.

HEDIS Performance Measure Selection and Descriptions

Each MCO underwent a full HEDIS compliance audit in 2022. 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 2021, Volume 2 Narrative*. The measurement year for the HEDIS measures is 2021, 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. The following age groups are reported: 20–44 years, 45–64 years, and 65+ years.

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
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 primary care provider (PCP) during their first 15 months of life; and
- Received two or more well-child visits for ages 15 months–30 months of life.

Childhood Immunization Status (Combinations 3, 7, and 10)
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. Across Combination 3, Combination 7, and Combination 10, all ten vaccinations are represented at least once.

Child and Adolescent Well-Care Visits
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 (Combination 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 years who had cervical cytology performed within the last 3 years;
- Women ages 30–64 years who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years; or
- Women ages 30–64 years 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). Four age groups are reported: ages 3–17 years, ages 18–64 years, ages 65 years and older, and total.

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). Four age groups are reported: ages 3 months–17 years, ages 18–64 years, ages 65 years and older, and total.

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). Four age groups are reported: ages 3 months–17 years, ages 18–64 years, ages 65 years and older, and total.

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
- Blood pressure (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
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 Acute Myocardial Infarction (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 sub measures 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
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 for each age group (18–64 years, 65 years and older, and total):

- 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 ages 16 and older with a diagnosis of OUD. Three age groups are reported: ages 18–64 years, 65 years and older, and total.

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 for 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 5.1H 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 2022 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.

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 2.13**. 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., 2022 [MY 2021] and 2021 [MY 2020]). In addition, statistical comparisons are made between the MY 2021 and MY 2020 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 2021 rates to MY 2020 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 Medicaid managed care (MMC) average for 2022 (MY 2021) 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 2021 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. [1] 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 2021 percentile column for PA-specific measures that do not have HEDIS percentiles to compare.

Table 2.2 to **Table 2.13** 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 2022 review year but were also identified as opportunities in 2021.

- It is recommended that GEI improve dental care for members. Annual Dental Visit and Annual Dental Visits for Members with Developmental Disabilities were both opportunities in 2022 and 2021.

[1] Please note that rates that are reported "per 100,000 members months" are not subject to the 3-percentage point limit. For these rates, if a rate has statistically significantly changed, it is reported as an opportunity.

- It is recommended that GEI improve services for its female members. Chlamydia Screening in Women and Contraceptive Care for Postpartum Women: LARC have been opportunities for improvement in both 2022 and 2021 across all age cohorts.
- It is recommended that GEI improve appropriate treatment for respiratory illness in its members. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis for members ages 3 months to 17 years old was an opportunity in 2021 and again in 2022.

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 2022 (MY 2021) MMC weighted average:
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44 years) – 6.0 percentage points;
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 45–64 years) – 3.8 percentage points;
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 65+ years) – 6.2 percentage points;
  - Use of First–Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1–11 years) – 12.5 percentage points; and
  - Use of First–Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1–17 years) – 6.6 percentage points.

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

Table 2.2: Access to/Availability of Care

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 20-44 years)	71,685	58,473	**81.6%**	81.3%	81.9%	81.4%	n.s.	75.5%	+	>= 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 45-64 years)	32,843	28,443	**86.6%**	86.2%	87.0%	87.0%	n.s.	82.8%	+	>= 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Ages 65+ years)	576	472	**81.9%**	78.7%	85.2%	79.7%	n.s.	75.7%	+	>= 25th and < 50th percentile
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11 years)	134	99	**73.9%**	66.1%	81.7%	77.3%	n.s.	61.4%	+	NA
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17 years)	252	170	**67.5%**	61.5%	73.4%	62.4%	n.s.	63.7%	n.s.	NA
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17 years)	386	269	**69.7%**	65.0%	74.4%	69.0%	n.s.	63.1%	+	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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

No strengths are identified for the Well-Care Visits and Immunizations performance measures.

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

- The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  - Childhood Immunizations Status (Combination 10) – 3.7 percentage points;
  - Body Mass Index: Percentile (Ages 12–17 years) – 6.9 percentage points;
  - Body Mass Index: Percentile (Total) – 4.5 percentage points;
  - Counseling for Nutrition (Ages 12–17 years) – 7.5 percentage points;
  - Counseling for Nutrition (Total) – 3.5 percentage points; and
  - Counseling for Physical Activity (Ages 12–17 years) – 6.2 percentage points.

Table 2.3: Well-Care Visits and Immunizations

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Well-Child Visits in the First 30 Months of Life (Ages 15 months ≥ 6 Visits)	4,468	2,915	**65.2%**	63.8%	66.6%	66.4%	n.s.	65.3%	n.s.	>= 75th and < 90th percentile
HEDIS	Well-Child Visits in the First 30 Months of Life (Ages 15-30 months ≥ 2 Visits)	4,810	3,552	**73.9%**	72.6%	75.1%	77.7%	-	71.6%	+	>= 75th and < 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (Ages 3-11 years)	44,884	28,301	**63.1%**	62.6%	63.5%	62.3%	+	65.3%	-	>= 50th and < 75th percentile
HEDIS	Child and Adolescent Well-Care Visits (Ages 12-17 years)	29,050	16,466	**56.7%**	56.1%	57.3%	58.2%	-	59.6%	-	>= 50th and < 75th percentile
HEDIS	Child and Adolescent Well-Care Visits (Ages 18-21 years)	16,490	5,477	**33.2%**	32.5%	33.9%	36.4%	-	35.6%	-	>= 75th and < 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (Total)	90,424	50,244	**55.6%**	55.2%	55.9%	56.7%	-	58.4%	-	>= 50th and < 75th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Childhood Immunizations Status (Combination 3)	411	274	**66.7%**	62.0%	71.3%	74.7%	-	69.3%	-	>= 50th and < 75th percentile
HEDIS	Childhood Immunizations Status (Combination 7)	411	234	**56.9%**	52.0%	61.8%	64.0%	-	59.1%	n.s.	>= 50th and < 75th percentile
HEDIS	Childhood Immunizations Status (Combination 10)	411	146	**35.5%**	30.8%	40.3%	39.9%	n.s.	39.2%	-	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Body Mass Index: Percentile (Ages 3-11 years)	185	151	**81.6%**	75.8%	87.5%	85.4%	n.s.	83.9%	-	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Body Mass Index: Percentile (Ages 12-17 years)	150	112	**74.7%**	67.4%	82.0%	85.5%	-	81.5%	-	>= 25th and < 50th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Body Mass Index: Percentile (Total)	335	263	**78.5%**	74.0%	83.1%	85.4%	-	83.0%	-	>= 25th and < 50th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Nutrition (Ages 3-11 years)	185	145	**78.4%**	72.2%	84.6%	76.8%	n.s.	78.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Nutrition (Ages 12-17 years)	150	100	**66.7%**	58.8%	74.5%	72.5%	n.s.	74.2%	-	>= 25th and < 50th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Nutrition (Total)	335	245	**73.1%**	68.2%	78.0%	75.2%	n.s.	76.6%	-	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Physical Activity (Ages 3-11 years)	185	136	**73.5%**	66.9%	80.1%	73.0%	n.s.	73.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Physical Activity (Ages 12-17 years)	150	102	**68.0%**	60.2%	75.8%	71.0%	n.s.	74.2%	-	>= 25th and < 50th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – Counseling for Physical Activity (Total)	335	238	**71.0%**	66.0%	76.0%	72.2%	n.s.	73.4%	-	>= 50th and < 75th percentile
HEDIS	Immunizations for Adolescents (Combination 1)	411	339	**82.5%**	78.7%	86.3%	87.8%	-	84.8%	n.s.	>= 50th and < 75th percentile

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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

No strengths are identified for the EPSDT: Screenings and Follow-up performance measures.

Opportunities for improvement are identified for the following EPSDT: Screenings and Follow-up performance measures:

- The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  - Developmental Screening in the First Three Years of Life – Total – 10.5 percentage points;
  - Developmental Screening in the First Three Years of Life – 1 year – 17.8 percentage points;
  - Developmental Screening in the First Three Years of Life – 2 years – 10.7 percentage points; and
  - Developmental Screening in the First Three Years of Life – 3 years – 3.9 percentage points.

Table 2.4: EPSDT: Screenings and Follow-up

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Lead Screening in Children (Age 2 years)	411	347	**84.4%**	80.8%	88.1%	88.3%	n.s.	81.6%	n.s.	>= 90th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	1,242	526	**42.4%**	39.6%	45.1%	47.4%	-	41.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Continuation Phase	479	212	**44.3%**	39.7%	48.8%	46.7%	n.s.	48.9%	n.s.	>= 25th and < 50th percentile
PA EQR	Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Initiation Phase	94	39	**41.5%**	31.0%	52.0%	47.8%	n.s.	39.9%	n.s.	NA
PA EQR	Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Continuation Phase	37	17	**46.0%**	28.5%	63.4%	48.2%	n.s.	48.1%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life—Total	14,148	7,109	**50.2%**	49.4%	51.1%	63.9%	-	60.8%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life—1 year	4,231	1,676	**39.6%**	38.1%	41.1%	61.0%	-	57.4%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life—2 years	5,119	2,599	**50.8%**	49.4%	52.2%	63.8%	-	61.5%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life—3 years	4,798	2,834	**59.1%**	57.7%	60.5%	67.0%	-	63.0%	-	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s." For comparison of MY 2021 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

Behavioral Health

Strengths are identified for the following Behavioral Health performance measures:

- The following rates are statistically significantly above/better than the 2022 (MY 2021) MMC weighted average:
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18–64 years – ED visits for mental illness, follow–up within 7 days) – 11.7 percentage points; and
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18–64 years – ED visits for mental illness, follow-up within 30 days) – 11.5 percentage points.

No opportunities for improvement are identified for the Behavioral Health performance measures.

Table 2.5: Behavioral Health

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages 18 to 64 years—ED visits for mental illness, follow-up within 7 days)	1,099	572	**52.1%**	49.1%	55.0%	61.6%	-	40.4%	+	NA
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages 18 to 64 years—ED visits for mental illness, follow-up within 30 days)	1,099	712	**64.8%**	61.9%	67.7%	70.9%	-	53.3%	+	NA
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years—ED visits for AOD abuse or dependence, follow-up within 7 days)	1,199	202	**16.9%**	14.7%	19.0%	19.4%	n.s.	19.1%	n.s.	NA
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years—ED visits for AOD abuse or dependence, follow-up within 30 days)	1,199	327	**27.3%**	24.7%	29.8%	30.5%	n.s.	29.0%	n.s.	NA
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages 65 years 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	29.2%	N/A	NA
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages 65 years and older—ED visits for mental illness, follow-up within 30 days)	0	0	**N/A**	N/A	N/A	N/A	N/A	64.3%	N/A	NA
PA EQR	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (Ages 65 years 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	25.0%	N/A	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Follow-up After Emergency Department Visit for Mental Illness (Ages 65 years and older—ED visits for mental illness, follow-up within 7 days)	0	0	**N/A**	N/A	N/A	N/A	N/A	50.0%	N/A	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s." For comparison of MY 2021 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.

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 2022 (MY 2021) MMC weighted average:
  - Sealant Receipt on Permanent First Molars (≥ 1 Molar) – 14.4 percentage points;
  - Sealant Receipt on Permanent First Molars (All 4 Molars) – 9.4 percentage points; and
  - Oral Evaluation, Dental Services (Ages < 1-20 years) – 3.5 percentage points.

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

- The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  - Annual Dental Visit (Ages 2–20 years) – 5.3 percentage points; and
    - Annual Dental Visits for Members with Developmental Disabilities (Ages 2-20 years) – 6.7 percentage points.

Table 2.6: EPSDT: Dental Care for Children and Adults

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Annual Dental Visit (Ages 2–20 years)	91,713	50,629	**55.2%**	54.9%	55.5%	45.7%	+	60.5%	-	>= 50th and < 75th percentile
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Ages 2–20 years)	6,338	3,475	**54.8%**	53.6%	56.1%	46.5%	+	61.5%	-	NA
PA EQR	Sealant Receipt on Permanent First Molars (≥ 1 Molar)	4,749	2,298	**48.4%**	47.0%	49.8%	46.2%	n.s.	34.0%	+	NA
PA EQR	Sealant Receipt on Permanent First Molars (All 4 Molars)	4,749	1,461	**30.8%**	29.4%	32.1%	35.1%	-	21.4%	+	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 21–35 years)	44,933	12,312	**27.4%**	27.0%	27.8%	27.3%	n.s.	28.5%	-	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 36–59 years)	47,557	12,249	**25.8%**	25.4%	26.2%	25.2%	+	26.6%	-	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 60–64 years)	6,918	1,561	**22.6%**	21.6%	23.6%	21.3%	n.s.	23.3%	n.s.	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 65 years and older)	573	85	**14.8%**	11.8%	17.8%	11.3%	n.s.	17.7%	n.s.	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Ages 21 years and older)	99,981	26,207	**26.2%**	25.9%	26.5%	25.7%	+	27.1%	-	NA
PA EQR	Adult Annual Dental Visit Women with a Live Birth (Ages 21–35 years)	2,957	911	**30.8%**	29.1%	32.5%	28.2%	+	31.9%	n.s.	NA
PA EQR	Adult Annual Dental Visit Women with a Live Birth (Ages 36–59 years)	385	114	**29.6%**	24.9%	34.3%	24.1%	n.s.	29.2%	n.s.	NA
PA EQR	Adult Annual Dental Visit Women with a Live Birth (Ages 21–59 years)	3,342	1,025	**30.7%**	29.1%	32.2%	27.7%	+	31.5%	n.s.	NA
PA EQR	Oral Evaluation, Dental Services (Ages < 1–20 years)	101,697	37,668	**37.0%**	36.7%	37.3%	NA	NA	33.6%	+	NA
PA EQR	Topical Fluoride for Children (Dental/Oral Health Services)	95,163	16,617	**17.5%**	17.2%	17.7%	NA	NA	17.4%	n.s.	NA
PA EQR	Topical Fluoride for Children (Dental Services)	95,163	12,349	**13.0%**	12.8%	13.2%	NA	NA	11.5%	+	NA
PA EQR	Topical Fluoride for Children (Oral Health Services)	95,163	-	**0.0%**	0.0%	0.0%	NA	NA	0.6%	NA	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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.

Women's Health

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

- The following rates are statistically significantly above/better than the 2022 (MY 2021) MMC weighted average:
  - Breast Cancer Screening (Ages 50–74 years) – 4.4 percentage points; and
  - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15–20) – 4.1 percentage points.

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

- The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  - Cervical Cancer Screening (Ages 21–64 years) – 5.1 percentage points;
  - Chlamydia Screening in Women (Ages 16–20 years) – 7.0 percentage points;
  - Chlamydia Screening in Women (Ages 21–24 years) – 4.2 percentage points;
  - Chlamydia Screening in Women (Total) – 5.9 percentage points;
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 15–20) – 5.9 percentage points;
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 15–20) – 6.1 percentage points;
  - Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 15–20) – 3.9 percentage points;
  - Contraceptive Care for Postpartum Women: LARC – 60 days (Ages 15–20) – 4.9 percentage points; and
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 21–44) – 3.2 percentage points.

Table 2.7: Women's Health

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Breast Cancer Screening (Ages 50–74 years)	8,587	4,752	**55.3%**	54.3%	56.4%	56.8%	n.s.	50.9%	+	>= 50th and < 75th percentile
HEDIS	Cervical Cancer Screening (Ages 21–64 years)	388	215	**55.4%**	50.3%	60.5%	62.4%	n.s.	60.5%	-	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Ages 16–20 years)	5,823	2,687	**46.1%**	44.9%	47.4%	47.3%	n.s.	53.2%	-	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Ages 21–24 years)	4,907	2,804	**57.1%**	55.7%	58.5%	56.7%	n.s.	61.4%	-	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Total)	10,730	5,491	**51.2%**	50.2%	52.1%	51.5%	n.s.	57.0%	-	>= 25th and < 50th percentile
HEDIS	Non-Recommended Cervical Cancer Screening in Adolescent Females[2]	10,690	96	**0.9%**	0.7%	1.1%	1.4%	-	0.3%	+	>= 10th and < 25th percentile
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20 years)	12,567	4,215	**33.5%**	32.7%	34.4%	35.2%	-	29.4%	+	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20 years)	12,567	393	**3.1%**	2.8%	3.4%	2.8%	n.s.	3.3%	n.s.	NA
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44 years)	38,489	10,257	**26.6%**	26.2%	27.1%	28.0%	-	26.6%	n.s.	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44 years)	38,489	1,507	**3.9%**	3.7%	4.1%	3.8%	n.s.	4.2%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 15 to 20 years)	279	24	**8.6%**	5.1%	12.1%	12.5%	n.s.	14.5%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 15 to 20 years)	279	106	**38.0%**	32.1%	43.9%	42.5%	n.s.	44.1%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 15 to 20 years)	279	13	**4.7%**	2.0%	7.3%	4.0%	n.s.	8.5%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 15 to 20 years)	279	31	**11.1%**	7.2%	15.0%	9.5%	n.s.	16.0%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 21 to 44 years)	2,589	423	**16.3%**	14.9%	17.8%	16.7%	n.s.	18.0%	-	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 21 to 44 years)	2,589	1,013	**39.1%**	37.2%	41.0%	42.6%	-	42.3%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 21 to 44 years)	2,589	108	**4.2%**	3.4%	5.0%	1.2%	+	5.6%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 21 to 44 years)	2,589	246	**9.5%**	8.4%	10.7%	6.9%	+	12.0%	-	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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 2022 (MY 2021) MMC weighted average:
  - Prenatal Screening for Smoking – 16.5 percentage points;
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 17.2 percentage points;
  - Prenatal Counseling for Environmental Tobacco Smoke Exposure – 10.4 percentage points;
  - Prenatal Screening for Depression – 9.7 percentage points;
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 20.0 percentage points;
  - Postpartum Screening for Depression – 9.7 percentage points; and
  - Postpartum Screening Positive for Depression – 6.0 percentage points.

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

- The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  - Prenatal Smoking Cessation – 9.3 percentage points.

Table 2.8: Obstetric and Neonatal Care

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Prenatal and Postpartum Care—Timeliness of Prenatal Care	411	355	**86.4%**	82.9%	89.8%	88.3%	n.s.	89.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Prenatal and Postpartum Care—Postpartum Care	411	329	**80.1%**	76.1%	84.0%	77.4%	n.s.	79.6%	n.s.	>= 50th and < 75th percentile
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking	424	392	**92.5%**	89.8%	95.1%	86.1%	+	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)	424	392	**92.5%**	89.8%	95.1%	86.1%	+	75.2%	+	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure	424	218	**51.4%**	46.5%	56.3%	54.9%	n.s.	47.3%	n.s.	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking	131	104	**79.4%**	72.1%	86.7%	82.3%	n.s.	71.8%	n.s.	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke Exposure	85	71	**83.5%**	75.1%	92.0%	82.5%	n.s.	73.1%	+	NA
PA EQR	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation	131	26	**19.9%**	12.6%	27.1%	14.4%	n.s.	29.1%	-	NA
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression	399	329	**82.5%**	78.6%	86.3%	71.4%	+	72.8%	+	NA
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	399	329	**82.5%**	78.6%	86.3%	69.3%	+	62.4%	+	NA
PA EQR	Perinatal Depression Screening: Prenatal Screening Positive for Depression	329	80	**24.3%**	19.5%	29.1%	27.2%	n.s.	20.9%	n.s.	NA
PA EQR	Perinatal Depression Screening: Prenatal Counseling for Depression	80	64	**80.0%**	70.6%	89.4%	68.3%	n.s.	77.3%	n.s.	NA
PA EQR	Perinatal Depression Screening: Postpartum Screening for Depression	352	306	**86.9%**	83.3%	90.6%	74.4%	+	77.2%	+	NA
PA EQR	Perinatal Depression Screening: Postpartum Screening Positive for Depression	306	71	**23.2%**	18.3%	28.1%	22.5%	n.s.	17.2%	+	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Perinatal Depression Screening: Postpartum Counseling for Depression	71	62	**87.3%**	78.9%	95.8%	83.1%	n.s.	86.9%	n.s.	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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 2022 (MY 2021) MMC weighted average:
  - Appropriate Testing for Pharyngitis (Ages 18–64 years) – 4.5 percentage points;
  - Appropriate Testing for Pharyngitis (Total) – 3.3 percentage points;
  - Asthma Medication Ratio (Ages 5–11 years) – 7.1 percentage points;
  - Asthma in Children and Younger Adults Admission Rate (Ages 2–17 years) Admissions per 100,000 member months – 5.4 percentage points;
  - Asthma in Children and Younger Adults Admission Rate (Total Ages 2–39 years) Admissions per 100,000 member months – 3.0 percentage points;
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40–64 years) Admissions per 100,000 member months – 7.4 percentage points; and
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+ years) Admissions per 100,000 member months – 7.1 percentage points.

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

- The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years) – 9.9 percentage points;
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total) – 5.1 percentage points; and
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older) Admissions per 100,000 member months – 21.5 percentage points.

Table 2.9: Respiratory Conditions

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Appropriate Testing for Pharyngitis (Ages 3–17 years)	2,042	1,500	**73.5%**	71.5%	75.4%	81.0%	-	73.7%	n.s.	>= 25th and < 50th percentile
HEDIS	Appropriate Testing for Pharyngitis (Ages 18–64 years)	1,805	1,017	**56.3%**	54.0%	58.7%	62.7%	-	51.9%	+	>= 25th and < 50th percentile
HEDIS	Appropriate Testing for Pharyngitis (Ages 65+ years)	1	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Appropriate Testing for Pharyngitis (Total)	3,848	2,517	**65.4%**	63.9%	66.9%	75.2%	-	62.1%	+	>= 25th and < 50th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 3 months–17 years)[2]	9,563	635	**93.4%**	92.9%	93.9%	91.2%	+	95.7%	-	>= 25th and < 50th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 18–64 years)[2]	4,729	807	**82.9%**	81.9%	84.0%	80.3%	+	85.5%	-	>= 50th and < 75th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Ages 65+ years)[2]	8	2	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Total)[2]	14,300	1,444	**89.9%**	89.4%	90.4%	88.3%	+	92.4%	-	>= 25th and < 50th percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years)[3]	449	152	**66.2%**	61.7%	70.6%	63.0%	n.s.	76.1%	-	>= 25th and < 50th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18–64 years)[3]	890	451	**49.3%**	46.0%	52.7%	47.7%	n.s.	49.5%	n.s.	>= 50th and < 75th percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65+ years)[3]	0	0	**N/A**	NA	NA	60.0%	NA	0.0%	NA	NA
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)[3]	1,339	603	**55.0%**	52.3%	57.7%	55.6%	n.s.	60.0%	-	>= 50th and < 75th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	620	157	**25.3%**	21.8%	28.8%	30.7%	-	24.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	492	401	**81.5%**	78.0%	85.0%	78.2%	n.s.	78.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	492	431	**87.6%**	84.6%	90.6%	84.5%	n.s.	87.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (Ages 5–11 years)	469	397	**84.7%**	81.3%	88.0%	84.0%	n.s.	77.6%	+	>= 90th percentile
HEDIS	Asthma Medication Ratio (Ages 12–18 years)	694	530	**76.4%**	73.1%	79.6%	75.5%	n.s.	72.4%	n.s.	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (Ages 19–50 years)	1,909	1,086	**56.9%**	54.6%	59.1%	57.3%	n.s.	59.2%	n.s.	>= 25th and < 50th percentile
HEDIS	Asthma Medication Ratio (Ages 51–64 years)	487	270	**55.4%**	50.9%	60.0%	53.3%	n.s.	60.0%	n.s.	>= 25th and < 50th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Asthma Medication Ratio (Total)	3,559	2,283	**64.2%**	62.6%	65.7%	65.5%	n.s.	65.4%	n.s.	>= 25th and < 50th percentile
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 2–17 years) – Admissions per 100,000 member months[4]	987,286	46	**4.7**	NA	NA	2.1	+	10.1	-	NA
PA EQR	Asthma in Children and Younger Adults Admission Rate (Ages 18–39 years) – Admissions per 100,000 member months[4]	900,869	45	**5.0**	NA	NA	4.4	+	5.5	-	NA
PA EQR	Asthma in Children and Younger Adults Admission Rate (Total Ages 2–39 years) – Admissions per 100,000 member months[4]	1,888,155	91	**4.8**	NA	NA	3.1	+	7.8	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years) – Admissions per 100,000 member months[4]	572,680	157	**27.4**	NA	NA	33.9	-	34.8	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older) – Admissions per 100,000 member months[4]	7,589	5	**65.9**	NA	NA	32.9	+	44.4	+	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+ years) – Admissions per 100,000 member months[4]	580,269	162	**27.9**	NA	NA	33.9	-	35.1	-	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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 members with URI (i.e., the proportion for whom antibiotics were not prescribed).
[3] Per NCQA, a higher rate indicates appropriate treatment of members 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; 2022 Rate N/A: not applicable, as denominator is less than 30

Comprehensive Diabetes Care

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

- The following rates are statistically significantly above/better than the 2022 (MY 2021) MMC weighted average:
  - HbA1c Poor Control (>9.0%) – 7.1 percentage points;
  - Retinal Eye Exam – 9.5 percentage points;
  - Blood Pressure Controlled <140/90 mm Hg – 11.5 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) – 6.0 percentage points.

No opportunities for improvement are identified for the Comprehensive Diabetes Care performance measures.

Table 2.10: Comprehensive Diabetes Care

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing	411	360	**87.6%**	84.3%	90.9%	86.6%	n.s.	85.2%	+	>= 50th and < 75th percentile
HEDIS	Comprehensive Diabetes Care – HbA1c Poor Control (> 9.0%)[2]	411	119	**29.0%**	24.4%	33.5%	33.6%	n.s.	36.1%	-	>= 90th percentile
HEDIS	Comprehensive Diabetes Care – HbA1c Control (< 8.0%)	411	229	**55.7%**	50.8%	60.6%	52.1%	n.s.	54.1%	n.s.	>= 75th and < 90th percentile
HEDIS	Comprehensive Diabetes Care – Retinal Eye Exam	411	266	**64.7%**	60.0%	69.5%	63.8%	n.s.	55.2%	+	>= 90th percentile
HEDIS	Comprehensive Diabetes Care – Blood Pressure Controlled < 140/90 mm Hg	411	323	**78.6%**	74.5%	82.7%	75.4%	n.s.	67.0%	+	>= 90th percentile
PA EQR	Diabetes Short-Term Complications Admission Rate (Ages 18 to 64 years) – Admissions per 100,000 member months[3]	1,473,549	274	**18.6**	16.4	20.8	24.2	-	18.2	n.s.	NA
PA EQR	Diabetes Short-Term Complications Admission Rate (Ages 65+ years) – Admissions per 100,000 member months[3]	7,589	1	**13.2**	0.0	39.0	0.0	+	9.0	n.s.	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years) – Admissions per 100,000 member months[3]	1,481,138	275	**18.6**	16.4	20.8	24.1	-	18.1	n.s.	NA
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy	4,919	3,375	**68.6%**	67.3%	69.9%	68.4%	n.s.	70.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%	3,375	2,496	**74.0%**	72.5%	75.5%	75.1%	n.s.	73.2%	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)	855	745	**87.1%**	84.8%	89.4%	87.1%	n.s.	81.1%	+	NA
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	84.4%	N/A	NA
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Total)	856	746	**87.1%**	84.8%	89.4%	83.3%	-	81.1%	-	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Ages 18–64 years)	9,562	4,129	**43.2%**	42.2%	44.2%	40.5%	+	41.2%	+	>= 75th and < 90th percentile
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Ages 65–74 years)	107	65	**60.8%**	51.0%	70.5%	37.6%	+	50.5%	n.s.	>= 90th percentile
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Ages 75–85 years)	39	25	**64.1%**	47.8%	80.4%	53.6%	n.s.	49.7%	n.s.	>= 90th percentile
HEDIS	Kidney Health Evaluation for Patients with Diabetes (Total)	9,708	4,219	**43.5%**	42.5%	44.5%	40.5%	+	41.5%	+	>= 75th and < 90th percentile

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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; 2022 Rate N/A: not applicable, as denominator is less than 30

Cardiovascular Care

Strengths are identified for the following Cardiovascular Care performance measures:

- The following rates are statistically significantly above/better than the 2022 (MY 2021) MMC weighted average:
  - Heart Failure Admission Rate (Ages 18–64 years) Admissions per 100,000 member months – 2.7 admissions per 100,000 member months; and
  - Heart Failure Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months – 2.9 admissions per 100,000 member months.

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

Table 2.11: Cardiovascular Care

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack	128	117	**91.4%**	86.2%	96.7%	90.2%	n.s.	86.5%	n.s.	>= 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	411	278	**67.6%**	63.0%	72.3%	71.5%	n.s.	65.2%	+	>= 75th and < 90th percentile
PA EQR	Heart Failure Admission Rate (Ages 18–64 years) Admissions per 100,000 member months[2]	1,473,549	269	**18.3**	16.1	20.4	15.9	n.s.	21.0	-	NA
PA EQR	Heart Failure Admission Rate (Ages 65+ years) Admissions per 100,000 member months[2]	7,589	6	**79.1**	15.8	142.3	82.2	n.s.	83.2	n.s.	NA
PA EQR	Heart Failure Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months[2]	1,481,138	275	**18.6**	16.4	20.8	16.3	n.s.	21.5	-	NA
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Ages 21–75 years (Male)	799	687	**86.0%**	83.5%	88.5%	85.5%	n.s.	84.7%	n.s.	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Ages 40–75 years (Female)	577	499	**86.5%**	83.6%	89.4%	84.9%	n.s.	83.5%	n.s.	>= 90th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate	1,376	1,186	**86.2%**	84.3%	88.0%	85.2%	n.s.	84.2%	n.s.	>= 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% Ages 21–75 years (Male)	687	532	**77.4%**	74.2%	80.6%	77.2%	n.s.	75.3%	n.s.	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% Ages 40–75 years (Female)	499	379	**76.0%**	72.1%	79.8%	77.9%	n.s.	75.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% Total Rate	1,186	911	**76.8%**	74.4%	79.3%	77.5%	n.s.	75.6%	n.s.	>= 75th and < 90th percentile
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (Ages 18–64 years)	14	10	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	>= 25th and < 50th percentile
HEDIS	Cardiac Rehabilitation Initiation: ≥ 2 Visits in 30 days (Ages 18–64 years)	433	11	**2.5%**	0.9%	4.1%	2.7%	n.s.	2.1%	n.s.	>= 50th and < 75th percentile
HEDIS	Cardiac Rehabilitation Initiation: ≥ 2 Visits in 30 days (Ages 65+ years)	1	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Cardiac Rehabilitation Initiation: ≥ 2 Visits in 30 days (Total)	434	11	**2.5%**	0.9%	4.1%	2.7%	n.s.	2.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Cardiac Rehabilitation Engagement 1: ≥ 12 Visits in 90 days (Ages 18–64 years)	433	15	**3.5%**	1.6%	5.3%	2.7%	n.s.	2.7%	n.s.	>= 50th and < 75th percentile
HEDIS	Cardiac Rehabilitation Engagement 1: ≥ 12 Visits in 90 days (Ages 65+ years)	1	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)	434	15	**3.5%**	1.6%	5.3%	2.7%	n.s.	2.7%	n.s.	>= 50th and < 75th percentile
HEDIS	Cardiac Rehabilitation Engagement 2: ≥ 24 Visits in 180 days (Ages 18–64 years)	433	11	**2.5%**	0.9%	4.1%	2.5%	n.s.	2.1%	n.s.	>= 25th and < 50th percentile
HEDIS	Cardiac Rehabilitation Engagement 2: ≥ 24 Visits in 180 days (Ages 65+ years)	1	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)	434	11	**2.5%**	0.9%	4.1%	2.4%	n.s.	2.2%	n.s.	>= 25th and < 50th percentile
HEDIS	Cardiac Rehabilitation Achievement: ≥ 36 Visits in 180 days (Ages 18–64 years)	433	3	**0.7%**	0.0%	1.6%	0.8%	n.s.	0.4%	n.s.	>= 25th and < 50th percentile
HEDIS	Cardiac Rehabilitation Achievement: ≥ 36 Visits in 180 days (Ages 65+ years)	1	0	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Cardiac Rehabilitation Achievement: ≥ 36 Visits in 180 days (Total)	434	3	**0.7%**	0.0%	1.6%	0.8%	n.s.	0.4%	n.s.	>= 25th and < 50th percentile

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s." For comparison of MY 2021 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; 2022 Rate N/A: not applicable, as denominator is less than 30.

Utilization

Strengths are identified for the following Utilization performance measures.

- The following rates are statistically significantly above/better than the 2022 (MY 2021) MMC weighted average:
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1–11 years) – 6.5 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12–17 years) – 3.8 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Ages 1–17 years) – 4.6 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Ages 1–17 years) – 3.9 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Ages 1–17 years) – 4.5 percentage points;
  - Pharmacotherapy for Opioid Use Disorder (Ages 16–64 years) – 6.3 percentage points; and
  - Pharmacotherapy for Opioid Use Disorder (Total Ages 16+ years) – 6.3 percentage points.

No opportunities for improvement are identified for the Utilization performance measures.

Table 2.12: Utilization

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	475	305	**64.2%**	59.8%	68.6%	61.7%	n.s.	61.3%	n.s.	>= 50th and < 75th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	856	557	**65.1%**	61.8%	68.3%	65.1%	n.s.	66.3%	n.s.	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1-11 years)	446	354	**79.4%**	75.5%	83.2%	70.9%	+	72.9%	+	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12-17 years)	955	776	**81.3%**	78.7%	83.8%	77.0%	+	77.4%	+	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Ages 1-17 years)	1,401	1,130	**80.7%**	78.6%	82.8%	74.8%	+	76.1%	+	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Ages 1-11 years)	446	331	**74.2%**	70.0%	78.4%	67.1%	+	69.0%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Ages 12-17 years)	955	654	**68.5%**	65.5%	71.5%	61.3%	+	65.3%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Ages 1-17 years)	1,401	985	**70.3%**	67.9%	72.7%	63.4%	+	66.4%	+	>= 90th percentile

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 1-11 years)	446	319	**71.5%**	67.2%	75.8%	64.5%	+	65.6%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 12-17 years)	955	642	**67.2%**	64.2%	70.3%	60.7%	+	63.4%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Ages 1-17 years)	1,401	961	**68.6%**	66.1%	71.1%	62.1%	+	64.1%	+	>= 90th percentile
HEDIS	Use of Opioids at High Dosage[2]	1,389	109	**7.9%**	6.4%	9.3%	7.4%	n.s.	7.9%	n.s.	>= 25th and < 50th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more prescribers)[3]	1,726	198	**11.5%**	9.9%	13.0%	13.7%	-	14.0%	-	>= 90th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more pharmacies)[3]	1,726	10	**0.6%**	0.2%	1.0%	0.4%	n.s.	1.2%	-	>= 90th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)[3]	1,726	4	**0.2%**	0.0%	0.5%	0.3%	n.s.	0.7%	-	>= 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 15 Days (Ages 18-64 years)[4]	10,896	281	**2.6%**	2.3%	2.9%	3.7%	-	3.3%	-	>= 75th and < 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 15 Days (Ages 65+ years)[4]	16	0	**N/A**	N/A	N/A	0.0%	N/A	6.6%	N/A	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
HEDIS	Risk of Continued Opioid Use - At Least 15 Days (Ages 18 years and older)[4]	10,912	281	**2.6%**	2.3%	2.9%	3.7%	-	3.3%	-	>= 75th and < 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 31 Days (Ages 18-64 years)[4]	10,896	164	**1.5%**	1.3%	1.7%	1.9%	-	2.0%	-	>= 75th and < 90th percentile
HEDIS	Risk of Continued Opioid Use - At Least 31 Days (Ages 65+ years)[4]	16	0	**N/A**	N/A	N/A	N/A	NA	2.7%	NA	NA
HEDIS	Risk of Continued Opioid Use - At Least 31 Days (Ages 18 years and older)[4]	10,912	164	**1.5%**	1.3%	1.7%	1.9%	-	2.0%	-	>= 75th and < 90th percentile
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Ages 18-64 years)[5]	1,375	266	**19.3%**	17.2%	21.5%	22.0%	n.s.	16.5%	+	NA
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Ages 65 years and older)[5]	5	2	**N/A**	N/A	N/A	N/A	NA	13.3%	NA	NA
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Total Ages 18 years and older)[5]	1,380	268	**19.4%**	17.3%	21.5%	22.0%	n.s.	16.5%	+	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 16-64 years)	1,842	523	**28.4%**	26.3%	30.5%	34.5%	-	22.1%	+	>= 50th and < 75th percentile
HEDIS	Pharmacotherapy for Opioid Use Disorder (Ages 65+ years)	1	1	**N/A**	N/A	N/A	N/A	NA	0.0%	NA	>= 90th percentile
HEDIS	Pharmacotherapy for Opioid Use Disorder (Total Ages 16+ years)	1,843	524	**28.4%**	26.3%	30.5%	34.5%	-	22.1%	+	>= 25th and < 50th percentile
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Total)	1,040	799	**76.8%**	74.2%	79.4%	78.7%	n.s.	76.2%	n.s.	NA

		2022 (MY 2021)					2022 (MY 2021) Rate Comparison[1]				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2021 (MY 2020) Rate	2022 Rate Compared to 2021	MMC	2022 Rate Compared to MMC	HEDIS 2022 Percentile
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)	1,040	766	**73.7%**	70.9%	76.4%	74.3%	n.s.	71.9%	n.s.	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Oral Naltrexone)	1,040	25	**2.4%**	1.4%	3.4%	3.0%	n.s.	2.8%	n.s.	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Long-Acting, Injectable Naltrexone)	1,040	41	**3.9%**	2.7%	5.2%	5.0%	n.s.	4.8%	n.s.	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Methadone)	1,040	1	**0.1%**	0.0%	0.3%	0.1%	n.s.	1.8%	-	NA

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s." For comparison of MY 2021 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; 2022 Rate N/A: not applicable, as denominator is less than 30

Table 2.13: Utilization (Continued)

		2022 (MY 2021)		2022 (MY 2021) Rate Comparison[1]		
Indicator Source	Indicator[2]	Count	Rate	2021 (MY 2020) Rate	2022 Rate Compared to 2021	HEDIS 2022 Percentile
HEDIS	Plan All-Cause Readmissions: Count of Index Hospital Stays (IHS)—Total Stays (Ages Total)	6,252		5,193		
HEDIS	Plan All-Cause Readmissions: Count of 30-Day Readmissions—Total Stays (Ages Total)	418		395		
HEDIS	Plan All-Cause Readmissions: Observed Readmission Rate—Total Stays (Ages Total)		**6.7%**	7.6%	NA	
HEDIS	Plan All-Cause Readmissions: Expected Readmission Rate—Total Stays (Ages Total)		**9.8%**	9.7%	NA	
HEDIS	Plan All-Cause Readmissions: Observed to Expected Readmission Ratio—Total Stays (Ages Total)		**0.7%**	0.8%	NA	

[1] For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s." For comparison of MY 2021 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

Table 2.14 and **Table 2.15** 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.

MY 2021 Adult CAHPS 5.1H Survey Results

Table 2.14: CAHPS MY 2021 Adult Survey Results

Survey Section/Measure	2022 (MY 2021)	2022 Rate Compared to 2021	2021 (MY 2020)	2021 Rate Compared to 2020	2020 (MY 2019)	2022 MMC Weighted Average
Your Health Plan						
Satisfaction with Adult's Health Plan (Rating of 8–10)	75.38%	▼	85.71%	▲	83.72%	78.90%
Getting Needed Information (Usually or Always)	91.84%	▲	88.54%	▼	91.59%	83.15%
Your Health Care in the Last 6 Months						
Satisfaction with Health Care (Rating of 8–10)	76.22%	▼	80.47%	▲	79.70%	77.33%
Appointment for Routine Care When Needed (Usually or Always)	84.25%	▼	85.45%	▲	78.97%	81.79%

▲▼ = Performance increased (▲) or decreased (▼) compared to prior year's rate.
Gray shaded boxes reflect rates above the MY 2021 MMC Weighted Average.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid managed care.

MY 2021 Child CAHPS 5.1H Survey Results

Table 2.15: CAHPS MY 2021 Child Survey Results

Survey Section/Measure	2022 (MY 2021)	2022 Rate Compared to 2021	2021 (MY 2020)	2021 Rate Compared to 2020	2020 (MY 2019)	2022 MMC Weighted Average
Your Child's Health Plan						
Satisfaction with Child's Health Plan (Rating of 8–10)	90.23%	▲	88.42%	▼	89.75%	86.94%
Information or Help from Customer Service (Usually or Always)	91.30%	▲	86.54%	▼	89.39%	83.40%
Your Healthcare in the Last 6 Months						
Satisfaction with Health Care (Rating of 8–10)	89.80%	▲	89.74%	▲	87.50%	86.28%
Appointment for Routine Care When Needed (Usually or Always)	82.98%	▼	89.10%	▼	92.51%	82.96%

▲▼ = Performance increased (▲) or decreased (▼) compared to prior year's rate.
Gray shaded boxes reflect rates above the MY 2021 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

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, 2021, 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 the database and then merged the RY 2021, 2020, and 2019 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 2021, 2020, and 2019), 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		✓
Cost Sharing	0		
Emergency and Post-Stabilization Services – Definition	4		✓
Emergency Services: Coverage and Payment	1		✓
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 System	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[2] 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 falls the individual regulatory categories appropriate to those headings. Findings will be further discussed relative to applicable subparts as indicated in the updated Protocol, i.e., Subpart D – MCO, PIHP and PAHP Standards and Subpart E – Quality Measurement and Improvement.

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

Findings

Of the 135 SMART Items, 88 items were evaluated and 47 were not evaluated for the MCO in RY 2021, RY 2020, or RY 2019. For categories where items were not evaluated for compliance for RY 2021, results from reviews conducted within the two prior years (RY 2020 and RY 2019) were evaluated to determine compliance, if available. Given that the MCO was found to be non-compliant in the Enrollment and Disenrollment category, IPRO recommends that particular focus is placed on improving infrastructure and accessibility related to this area going forward.

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

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

ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. [*Title 42 CFR § 438.100 (a), (b)*].

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 4 items and was compliant on 4 items based on RY 2021.
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 2021.
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 2021.
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 2021.
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 2021.

GEI was evaluated against 11 of the 15 SMART Items crosswalked to Enrollee Rights and Protections Regulations and was compliant on all 11 items. GEI was found to be compliant on all six 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. [*Title 42 CFR § 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 in **bold** type. 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[1]	**Compliance**	**Comments**
Availability of Services	Compliant	14 items were crosswalked to this category. The MCO was evaluated against 11 items and was compliant on 11 items based on RY 2021.

MCO, PIHP AND PAHP STANDARDS REGULATIONS		
Subpart D: Categories[1]	**Compliance**	**Comments**
Assurances of Adequate Capacity and Services	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2021.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on 12 items based on RY 2021.
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 2021.
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 2021.
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 2021.
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 2021.
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 2021.
Grievance and Appeal System	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2021.
Subcontractual Relationships and Delegations	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2021.
Practice Guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2021.
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 2021.

[1]Regulations that have been designated as required under the updated protocols are in bold type. The remaining two are related standards.

GEI was evaluated against 52 of 71 SMART Items that were crosswalked to MCO, PIHP and PAHP Standards Regulations and was compliant on 52 items. Of the 12 categories in MCO, PIHP and PAHP Standards, GEI was found to be compliant on all 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. [*Title 42 CFR § 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 in **bold** type.

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[1]	**Compliance**	**Comments**
Quality Assessment and Performance Improvement Program (QAPI)	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 9 items and was compliant on 9 items based on RY 2021.

[1]The regulation, which has been designated as required under the updated protocols, is in bold type.

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

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 Systems 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 2021.
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 2021.
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 2021.
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 2021.
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 2021.
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 2021.
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 2021.

GRIEVANCE AND APPEAL SYSTEM REGULATIONS		
Subpart F: Categories	**Compliance**	**Comments**
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 2021.
Effectuation of Reversed Resolutions	Compliant	Per NCQA Accreditation, 2022. (See "Accreditation Status" below)

GEI was evaluated against 13 of the 40 SMART Items crosswalked to the Grievance and Appeal System and was compliant on all 13 items. GEI was found to be compliant for all nine categories of the Grievance and Appeal System. For the category of Effectuation of Reversed Resolutions, per the NCQA website, the plan remains Accredited.

Accreditation Status

GEI underwent an NCQA Accreditation Survey evaluation June 30, 2022, due to the ongoing 2019 novel coronavirus (COVID-19) pandemic, which is effective through September 26, 2023. 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 [primary care case management] PCCM entity has effectively addressed the recommendations for quality improvement (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 2021 EQR Technical Reports, which were distributed May 2022. The 2022 EQR is the fourteenth to include descriptions of current and proposed interventions from each PH MCO that address the recommendations from the prior year's reports.

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, 2022, 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 2022, as well as any additional relevant documentation provided by Geisinger Health Plan.

The embedded Word document presents Geisinger Health Plan's responses to opportunities for improvement cited by IPRO in the 2021 EQR Technical Report, detailing current and proposed interventions.

GEI 2021 Opps
Response Request F

Root Cause Analysis and Action Plan

The 2022 EQR is the thirteenth year MCOs were required to prepare a Root Cause Analysis and Action Plan for measures on the HEDIS MY 2021 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;
- A root cause analysis and analysis findings;
- An 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.

Geisinger Health Plan submitted an initial Root Cause Analysis and Action Plan in September 2022. For each measure in grade categories D and F, Geisinger Health Plan completed the embedded form, identifying factors contributing to poor performance.

Root_Cause_Analysi
s_GEI_Response_For

For the 2021 EQR, Geisinger Health Plan was required to prepare a Root Cause Analysis and Action Plan for the following performance measures, which are detailed in **Table 4.1**.

Geisinger Health Plan Response to Previous EQR Recommendations

Table 4.1 displays Geisinger Health Plan's progress related to the *2021 External Quality Review Report,* as well as IPRO's assessment of Geisinger Health Plan's response.

Table 1: Geisinger Health Plan Response to Previous EQR Recommendations

Recommendation for Geisinger Health Plan	IPRO Assessment of MCO Response[1]
Improve Annual Dental Visit (Ages 2–20 years)	Partially addressed
Improve Annual Dental Visits for Members with Developmental Disabilities (Ages 2-20 years)	Partially addressed
Improve Adult Annual Dental Visit ≥ 21 Years (Ages 65 years and older)	Addressed
Improve Adult Annual Dental Visit Women with a Live Birth (Ages 36-59 years)	Addressed
Improve Chlamydia Screening in Women (Total)	Partially addressed
Improve Chlamydia Screening in Women (Ages 16-20 years)	Not addressed
Improve Chlamydia Screening in Women (Ages 21-24 years)	Not addressed
Improve Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20 years	Partially addressed
Improve Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20 years)	Partially addressed
Improve Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21 to 44 years)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44 years)	Addressed
Improve Prenatal Smoking Cessation	Partially addressed
Improve Appropriate Treatment for Upper Respiratory Infection (Ages 3 months-17 years)	Addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months-17 years)	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	Not addressed
Improve Diabetes Short-Term Complications Admission Rate (Ages 18-64 years) Admissions per 100,000 member months	Addressed
Improve Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Addressed
Improve Use of Pharmacotherapy for Opioid Use Disorder (Total)	Partially addressed

[1] IPRO assessments are as follows: **addressed**: MCO'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**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
EQR: external quality review; MCO: managed care organization.

V: Strengths, Opportunities for Improvement, and EQR Recommendations

The review of the MCO's MY 2021 performance 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.

Strengths

- GEI was found to be compliant on one element reviewed for the Preventing Inappropriate Use or Overuse of Opioids PIP.

- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2022 (MY 2021) on the following measures:
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44 years);
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 45–64 years);
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 65+ years);
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1–11 years);
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1–17 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 years – 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);
  - Oral Evaluation, Dental Services (Ages < 1–20 years);
  - Breast Cancer Screening (Ages 50–74 years);
  - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15–20 years);
  - Prenatal Screening for Smoking;
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator);
  - Prenatal Counseling for Environmental Tobacco Smoke Exposure;
  - Prenatal Screening for Depression;
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator);
  - Postpartum Screening for Depression;
  - Postpartum Screening Positive for Depression;
  - Appropriate Testing for Pharyngitis (Ages 18–64 years);
  - Appropriate Testing for Pharyngitis (Total);
  - Asthma Medication Ratio (Ages 5–11 years);
  - Asthma in Younger Adults Admission Rate (Ages 2–17 years) Admissions per 100,000 member months;
  - Asthma in Younger Adults Admission Rate (Total Ages 2–39 years) Admissions per 100,000 member months;
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years) Admissions per 100,000 member months;
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+ years) Admissions 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);
  - Heart Failure Admission Rate (Ages 18–64 years) Admissions per 100,000 member months;
  - Heart Failure Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1–11 years);

- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12–17 years);
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Ages 1–17 years);
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Ages 1–17 years);
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Ages 1–17 years);
- Pharmacotherapy for Opioid Use Disorder (Ages 16–64 years); and
- Pharmacotherapy for Opioid Use Disorder (Total Ages 16+ years).

- GEI was found to be fully compliant on all categories in all state and federal managed care regulations.

Opportunities for Improvement

- GEI was found to be partially compliant on all three elements and non-compliant on one element reviewed for the Preventing Inappropriate Use or Overuse of Opioids PIP.
- GEI was found to be partially compliant on four elements and non-compliant on one element for the Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits PIP.

- The MCO's performance was statistically significantly below/worse than the MMC rate in 2022 (MY 2021) as indicated by the following measures:
  - Childhood Immunizations Status (Combination 10);
  - Body Mass Index: Percentile (Ages 12–17 years);
  - Body Mass Index: Percentile (Total);
  - Counseling for Nutrition (Ages 12–17 years);
  - Counseling for Nutrition (Total);
  - Counseling for Physical Activity (Ages 12–17 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;
  - Annual Dental Visit (Ages 2–20 years);
  - Annual Dental Visits for Members with Developmental Disabilities (Ages 2–20 years);
  - Cervical Cancer Screening (Ages 21–64 years);
  - Chlamydia Screening in Women (Ages 16–20 years);
  - Chlamydia Screening in Women (Ages 21–24 years);
  - Chlamydia Screening in Women (Total);
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 15–20 years);
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 15–20 years);
  - Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 15–20 years);
  - Contraceptive Care for Postpartum Women: LARC – 60 days (Ages 15–20 years);
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 21 to 44 years);
  - Prenatal Smoking Cessation;
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years);
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total); and
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older) Admissions per 100,000 member months.

Additional targeted opportunities for improvement are found in the MCO–specific HEDIS MY 2021 P4P Measure Matrix that follows.

P4P Measure Matrix Report Card 2022 (MY 2021)

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 Healthcare Effectiveness Data Information Set (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 2022 (MY 2021) and 2021 (MY 2020); and
2. Compares the MCO's MY 2021 P4P measure rates to the MY 2021 Medicaid Managed Care (MMC) Weighted Average, or the MCO Average as applicable.

A matrix represents the comparisons in each of **Figures 5.1** and **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 an 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 an MCO's performance for these P4P measures are 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 2021 rate is above/better than the MY 2021 average and above/better than the MCO's MY 2020 rate.

The light green boxes (B) indicate either that the MCO's MY 2021 rate does not differ from the MY 2021 average and is above/better than MY 2020, or that the MCO's MY 2021 rate is above/better than the MY 2021 average but there is no change from the MCO's MY 2020 rate.

The yellow boxes (C) indicate that the MCO's MY 2021 rate is below/worse than the MY 2021 average and is above/better than the MY 2020 rate, or the MCO's MY 2021 rate does not differ from the MY 2021 average and there is no change from MY 2020, or the MCO's MY 2021 rate is above/better than the MY 2021 average but is lower/worse than the MCO's MY 2020 rate. No action is required although MCOs should identify continued opportunities for improvement.

The orange boxes (D) indicate either that the MCO's MY 2021 rate is lower/worse than the MY 2021 average and there is no change from MY 2020, or that the MCO's MY 2021 rate is not different than the MY 2021 average and is lower/worse than the MCO's MY 2020 rate. ***A root cause analysis and plan of action is therefore required.***

The red box (F) indicates that the MCO's MY 2021 rate is below/worse than the MY 2021 average and is below/worse than the MCO's MY 2020 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.

- No P4P measures fell into this comparison category.

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

- No P4P measures fell into this comparison category.

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

Measure(s) that in MY 2021 did not statistically significantly change from MY 2020, and are not statistically significantly different from the MY 2021 MMC weighted average:

- Controlling High Blood Pressure
- Prenatal Care in the First Trimester
- Lead Screening in Children

Measure(s) that in MY 2021 are statistically significantly above/better than MY 2020, and are statistically significantly below/worse than the MY 2021 MMC weighted average:

- Annual Dental Visit (Ages 2—20 years)
- Well–Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[3]
- Child and Adolescent Well-Care Visits (Ages 3—21 years) [4]

D – Root cause analysis and plan of action required.

Measure(s) that in MY 2021 did not statistically significantly change from MY 2020, but are statistically significantly lower/worse than the MY 2021 MMC weighted average:

- Comprehensive Diabetes Care: HbA1c Poor Control[5]
- Postpartum Care
- Asthma Medication Ratio

F – Root cause analysis and plan of action required.

Measure(s) that in MY 2021 are statistically significantly lower/worse than MY 2020, and are statistically significantly lower/worse than the MY 2021 MMC weighted average:

- Developmental Screening in the First Three Years of Life
- Plan All Cause Readmissions[6]

[3] Effective MY 2020, Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaced Well-Child Visits in the First 15 Months of Life, 6 or more.
[4] Child and Adolescent Well-Care Visits (Ages 3—21 years) was added as a P4P measure in 2022 (MY 2021).
[5] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.
[6] Lower rates for Plan All Cause Readmissions indicate better performance.

Figure 5.1: P4P Measure Matrix – Rate Measures

	Medicaid Managed Care Weighted Average Statistical Significance Comparison			
Year to Year Statistical Significance Comparison	**Trend**	**Below/Worse than Average**	**Average**	**Above/Better than Average**
	⬆	**C** Annual Dental Visit (Ages 2—20 years) Well–Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) [7] Child and Adolescent Well-Care Visits (Ages 3—21 years) [8]	**B**	**A**
	No Change	**D** Comprehensive Diabetes Care: HbA1c Poor Control[9] Postpartum Care Asthma Medication Ratio	**C** Controlling High Blood Pressure Prenatal Care in the First Trimester Lead Screening in Children	**B**
	⬇	**F** Developmental Screening in the First Three Years of Life	**D**	**C**

[7] Effective MY 2020, Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaced Well-Child Visits in the First 15 Months of Life, 6 or more.
[8] Child and Adolescent Well-Care Visits (Ages 3—21 years) was added as a P4P measure in 2022 (MY 2021).
[9] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.

Figure 5.2: P4P Measure Matrix – PCR Ratio Measure

	Medicaid Managed Care Weighted Average Statistical Significance Comparison			
Year to Year Statistical Significance Comparison	Trend	Below/Worse than Average	Average	Above/Better than Average
	⬆	C	B	A
	No Change	D	C	B
	⬇	F Plan All Cause Readmissions[10]	D	C

[10] Lower rates for Plan All Cause Readmissions indicate better performance.

P4P performance measure rates for 2019 (MY 2018), 2020 (MY 2019), 2021 (MY 2020), and 2022 (MY 2021) 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*	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2022 (MY 2021) MMC WA
Comprehensive Diabetes Care – HbA1c Poor Control[11]	29.1% =	29.1% =	33.6% =	29.0% =	36.1%
Controlling High Blood Pressure	71.8% =	71.8% =	71.5% =	67.6% =	65.2%
Prenatal Care in the First Trimester	85.2% =	91.7% ▲	88.3% =	86.4% =	89.0%
Postpartum Care	68.6% =	82.0% ▲	77.4% =	80.1% =	79.6%
Annual Dental Visits (Ages 2 – 20 years)	58.5% ▲	54.4% ▼	45.7% ▼	55.2% ▲	60.5%
Well–Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits)[12]	74.1% =	74.1% =	66.4% ▼	65.2% =	65.3%
Child and Adolescent Well-Care Visits (Ages 3—21 years)[13]				55.6% ▼	58.4%
Asthma Medication Ratio			65.5% =	64.2% =	65.4%
Lead Screening in Children		82.2% =	88.3% ▲	84.4% =	81.6%
Quality Performance Measure – Other Percentage Rate Metric	**2019 (MY 2018) Rate**	**2020 (MY 2019) Rate**	**2021 (MY 2020) Rate**	**2022 (MY 2021) Rate**	**2022 (MY 2021) MMC WA**
Developmental Screening in the First Three Years of Life (CMS Child Core)		65.4% ▲	63.9% ▼	50.2% ▼	60.8%
Quality Performance Measure – HEDIS Ratio Metric	**HEDIS 2019 (MY 2018) Ratio**	**HEDIS 2020 (MY 2019) Ratio**	**HEDIS 2021 (MY 2020) Ratio**	**HEDIS 2022 (MY 2021) Rate**	**HEDIS 2022 (MY 2021) MCO Average**
Plan All–Cause Readmissions[14]			0.78 ▼	0.68 =	0.97

* Statistically significant difference is indicated for all measures except Plan All–Cause Readmissions. For this measure, differences are

P4P: Pay–for–Performance; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; MMC: Medicaid Managed Care; WA: weighted average.

[11] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.
[12] Effective MY 2020, Well-Child Visits in the First 30 Months: First 15 Months of Life (6 or more visits) replaced Well-Child Visits in the First 15 Months of Life, 6 or more.
[13] Child and Adolescent Well-Care Visits (Ages 3—21 years) was added as a P4P measure in 2022 (MY 2021).
[14] Lower rates for Plan All Cause Readmissions indicate better performance.

Table 5.2: EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Performance Improvement Projects (PIPs)		
Preventing Inappropriate Use or Overuse of Opioids	It was again recommended that the MCO review guidance previously provided during the Proposal and Interim periods regarding the MCO baseline rates and discussion around why this project topic is an area of opportunity for GEI, including examining plan-specific data and rates for opportunities for improvement and ways to address disparities.	Quality
	Previously, 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. The plan was strongly encouraged to carefully review the previous recommendations given and to use the PIP template as a direct guide for the appropriate development of this PIP.	Quality
	It was previously recommended that GEI utilize formal root cause analyses such as the 5 Whys and other modalities to determine underlying causes of their barriers. Related to this, it was recommended that the plan obtain direct member or provider feedback to identify barriers.	Quality
	It was again 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
	It was again recommended that GEI complete the Discussion section, currently for the second Interim Report. This is 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
	It was recommended that the plan update descriptions of changes to the project within the applicable sections of the PIP document as noted in the findings.	Quality
	It was again recommended that the MCO review guidance previously provided during the Proposal and Interim periods regarding the MCO baseline rates and discussion around why this project topic is an area of opportunity for GEI, including examining plan-specific data and rates for opportunities for improvement and ways to address disparities.	Quality
Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits	It was again strongly recommended that GEI use the guidance provided during Proposal and Interim reviews in conjunction with the example AIMs statement provided within the PIP template to revise the AIMs and Objectives section as indicated.	Quality

Measure/Project	IPRO's Recommendation	Standards
	The plan was strongly encouraged to carefully review the previous recommendations given and to use the PIP template as a direct guide for the appropriate development of this PIP. Related to this, it was recommended that the plan address the recommendations for Indicator 4, including delineation of Initiation and Engagement measures within table 3.	Quality
	It was again recommended that the project timeline be updated to reflect specific start dates for better tracking throughout the lifetime of the PIP.	Quality
	It was previously 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. This was not addressed and remains a recommendation.	Quality
	It was again recommended that GEI complete the Discussion section, currently for the second Interim Report. This is 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
	It was recommended that the plan fully populate Implementation Period and Interim Submission dates within the applicable sections of the PIP document as noted in the findings.	Quality
Performance Measures and CAHPS Survey		
Annual Dental Visits	It is recommended that GEI improve dental care for members. Annual Dental Visit and Annual Dental Visits for Members with Developmental Disabilities were both opportunities in 2022 and 2021.	Access
Women's Health Screenings	It is recommended that GEI improve services for its female members. Chlamydia Screening in Women and Contraceptive Care for Postpartum Women: LARC have been opportunities for improvement in both 2022 and 2021 across all age cohorts.	Access
Appropriate Respiratory Illness Treatment	It is recommended that GEI improve appropriate treatment for respiratory illness its members. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis for members 3 months to 17 years old was an opportunity in 2021 and again in 2022	Access
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

EQR: external quality review; MCO: managed care organization; ITM: intervention tracking measure; ED: emergency department; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CHIP: Children's Health Insurance Plan; N/A: not applicable.

VI: Summary of Activities

Performance Improvement Projects

- As previously noted, GEI's Opioid and Readmission PIP interim 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 2022 for which the MCO had a sufficient denominator.

Structure and Operations Standards

- With state and federal managed care regulations reviewed, GEI was found to be fully compliant on all contracts. Compliance review findings for GEI from RY 2022, RY 2021, and RY 2020 were used to make the determinations.

2021 Opportunities for Improvement MCO Response

- GEI provided a response to the opportunities for improvement issued in the 2021 annual technical report and a root cause analysis and action plan for those measures on the HEDIS 2021 P4P Measure Matrix receiving either "D" or "F" ratings.

2022 Strengths and Opportunities for Improvement

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

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).