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

2020 External Quality Review Report
Geisinger Health Plan

Final Report
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IPRO
Better healthcare, realized.

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Introduction

Purpose and Background

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

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

- validation of performance improvement projects,
- validation of MCO performance measures, and
- review to determine MCO compliance with structure and operations standards established by the State.

HealthChoices Physical Health (PH) is the mandatory managed care program that provides Medical Assistance (MA) recipients with physical health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) contracted with IPRO as its EQRO to conduct the 2020 EQRs for the HealthChoices PH MCOs and to prepare the technical reports. This technical report includes six core sections:

I. Performance Improvement Projects
II. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
III. Structure and Operation Standards
IV. 2019 Opportunities for Improvement – MCO Response
V. 2020 Strengths and Opportunities for Improvement
VI. Summary of Activities

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

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

For the PH Medicaid MCOs, the information for the compliance with Structure and Operations Standards in Section III of the report is derived from the commonwealth's monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from the HealthChoices Agreement, and from National Committee for Quality Assurance (NCQA™) accreditation results for each MCO. This section also contains discussion of the revisions to the required structure and compliance standards presented in the updated EQR protocols.

Section IV, 2019 Opportunities for Improvement – MCO Response, includes the MCO's responses to the 2019 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: Performance Improvement Projects

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The 2020 EQR is the seventeenth year to include validation of PIPs. For each PIP, all PH MCOs shared the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions, and timeliness.

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

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

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

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by the Centers for Medicare & Medicaid Services (CMS), incorporates Lean methodologies and principles, and meets the requirements of the final rule on EQR of Medicaid and CHIP MCOs issued in May 2016. IPRO's review evaluates each project against seven review elements covering all areas required by CMS's 2019 EQR Protocols:

1. Project Topic
2. Methodology
3. Barrier Analysis, Interventions, and Monitoring
4. Discussion
5. Next Steps
6. Validity and Reliability of PIP Results

The first five elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement.

Review Element Designation/Weighting

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. MY 2019 is the baseline year, and during the 2020 review year, elements were reviewed and scored at multiple points during the year once proposal reports were submitted in October 2020. All MCOs received some level of guidance towards improving their proposals in these findings, and MCOs responded accordingly with resubmission to correct specific areas.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points

can be awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. For the current PIPs, compliance levels were assessed, but no formal scoring was provided.

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

Table 1.1: Element Designation

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

Scoring Matrix

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 new PIP cycle during the review year.

In late 2019, DHS advised IPRO of the PIP topics that DHS wanted to implement for the PIP to begin in 2020. 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 2020, the initial year of the cycle, there were several levels of communication provided to MCOs before and after their Project Proposal submissions, including:

- An overall summary document outlining introduction to the new PIP cycle, as well as background for both PIPs and expectations for MCOs in terms of identification of barriers and subsequent development of interventions.
- A PIP training held with all MCOs in September 2020. The training covered the Lean process and related PIP templates, as well as the background and expectations for each PIP.
- A Q&A document was updated and maintained. The document was distributed following the training and as needed when updated with additional questions.
- MCO-specific review findings for each PIP, including detailed information to assist MCOs in preparing their proposal resubmissions.
- Conference calls as requested with each MCO to discuss the PIP proposal review findings with key MCO staff assigned to each PIP topic.

As noted above, for the current review year, 2020, MCOs were requested to submit a Project Proposal, including baseline rates. Review teams consisted of one clinical staff member and one analytical staff member. Following initial review, MCOs were asked to update their submission according to the recommendations noted in the findings.

Preventing Inappropriate Use or Overuse of Opioids

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

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

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

is an MCO-defined measure, not HEDIS. It is acceptable to use HEDIS for target benchmarks, but the MCO must be careful to specify measures and benchmarks as it is not a direct comparison.

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

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

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

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

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 risk in membership. Also, they should provide member data for disease prevalence or acute-care utilization, which would include information about racial disparities evident in prevalence or utilization to identify populations at risk and target interventions. This recommendation was not addressed.

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

Similar to the Preventing Inappropriate Use or Overuse of Opioids PIP, for the Reducing Potentially Preventable Hospital Admissions, Readmissions, and ED visits PIP, DHS selected eight performance measures to be included in the PIPs across all MCOs. Three measures are to be collected via HEDIS. The remaining five, all ICP measures, are to be defined by the MCO with certain predetermined parameters. Most of the proposal review recommendations provided to GEI were not addressed. As noted in the PIP review, Performance Indicator 4, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, is missing the baseline rate. Likewise, Performance Indicator 8, Inpatient 30-Day Readmission Rate for Individuals with SPMI, is missing the baseline and target rates. It should be noted that, as indicated in the proposal documents to the MCOs and training, both Indicators 4 and 8 are required for the PIP and are required to be defined and collected by the MCO, using data from their own systems. Additionally, Performance Indicator 1, Ambulatory Care: Emergency Department Visits, Indicator 2, Inpatient Utilization: Total Discharges, Indicator 4, and Indicator 7, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, have rationales for their target rates that reference the

Quality Compass. It is recommended that the MCO clarify if the target rates are referencing the HEDIS 2020 (MY 2019) Quality Compass year. In addition, percentiles should be specified in the target rate rationales for Performance Indicators 1 and 4.

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

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

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

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

Table 1.2: GEI PIP Compliance Assessments

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

II: Performance Measures and CAHPS Survey

Methodology

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

The MCOs were provided with final specifications for the PA Performance Measures from December 2019 to June 2020. Source code, raw data, and rate sheets were submitted by the MCOs to IPRO for review in 2020. 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. Additional resubmissions required discussion with and approval from DHS. Pseudo code was reviewed by IPRO. Raw data were also reviewed for reasonability, and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally, MCOs were provided with comparisons to the previous year's rates and were requested to provide explanations for highlighted differences. For measures reported as percentages, differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates. For measures not reported as percentages (e.g., adult admission measures), differences were highlighted based only on statistical significance, with no minimum threshold.

For each of three PA performance Birth-related measures—Cesarean Rate for Nulliparous Singleton Vertex (CRS), Live Births Weighing Less Than 2,500 Grams (PLB), and Elective Delivery—rates were produced utilizing MCO Birth files in addition to the 2020 (MY 2019) Department of Health Birth File. IPRO requested, from each MCO, information on members with a live birth within the measurement year. IPRO then utilized the MCO file in addition to the most recent applicable PA Department of Health Birth File to identify the denominator, numerator, and rate for the three measures.

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

Evaluation of MCO performance is based on both PA-specific performance measures and selected HEDIS measures for the EQR. A list of the performance measures included in this year's EQR report is presented in **Table 2.1**.

Table 2.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
HEDIS	Children and Adolescents' Access to PCPs (Age 12–24 months)
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months–6 years)
HEDIS	Children and Adolescents' Access to PCPs (Age 7–11 years)
HEDIS	Children and Adolescents' Access to PCPs (Age 12–19 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 20–44 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 45–64 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years)
HEDIS	Adult Body Mass Index Assessment (Age 18–74 years)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total Ages 1 to 17)
Well-Care Visits and Immunizations	
HEDIS	Well-Child Visits in the First 15 Months of Life (6+ Visits)
HEDIS	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)
HEDIS	Childhood Immunizations Status by Age 2 (Combination 2)
HEDIS	Childhood Immunizations Status by Age 2 (Combination 3)

Source	Measures
HEDIS	Adolescent Well-Care Visits (Age 12 to 21 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index: Percentile (Age 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index: Percentile (Age 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 (Age 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Age 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 (Age 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Age 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
PA EQR	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)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64—ED visits for mental illness, follow-up within 30 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for mental illness, follow-up within 30 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 65 and older—ED visits for mental illness, follow-up within 7 days)
Dental Care for Children and Adults	
HEDIS	Annual Dental Visit (Age 2–20 years)
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2–20 years)
PA EQR	Dental Sealants for 6- to 9-Year-Old Children at Elevated Caries Risk (CHIPRA)
PA EQR	Dental Sealants for 6- to 9-Year-Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 21–35 years)

Source	Measures
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 36–59 years)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 60–64 years)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 65 years and older)
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 21 years and older)
Women's Health	
HEDIS	Breast Cancer Screening (Age 50–74 years)
HEDIS	Cervical Cancer Screening (Age 21–64 years)
HEDIS	Chlamydia Screening in Women (Total)
HEDIS	Chlamydia Screening in Women (Age 16–20 years)
HEDIS	Chlamydia Screening in Women (Age 21–24 years)
HEDIS	Non-Recommended Cervical Cancer Screening in Adolescent Females
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Ages 21 to 44)
Obstetric and Neonatal Care	
HEDIS	Prenatal and Postpartum Care—Timeliness of Prenatal Care
HEDIS	Prenatal and Postpartum Care—Postpartum Care
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams
PA EQR	Elective Delivery
Respiratory Conditions	
HEDIS	Appropriate Testing for Pharyngitis (Total—Age 3 years and older)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Total—Age 3 months and older)
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total—Age 3 months and older)
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	Medication Management for People with Asthma—75% Compliance (Age 5–11 years)
HEDIS	Medication Management for People with Asthma—75% Compliance (Age 12–18 years)
HEDIS	Medication Management for People with Asthma—75% Compliance (Age 19–50 years)
HEDIS	Medication Management for People with Asthma—75% Compliance (Age 51–64 years)
HEDIS	Medication Management for People with Asthma—75% Compliance (Total—Age 5–64 years)
HEDIS	Asthma Medication Ratio (5–11 years)
HEDIS	Asthma Medication Ratio (12–18 years)
HEDIS	Asthma Medication Ratio (19–50 years)
HEDIS	Asthma Medication Ratio (51–64 years)
HEDIS	Asthma Medication Ratio (Total)
PA EQR	Asthma in Children and Younger Adults Admission Rate (Age 2–17 years)—Admission per 100,000 member months
PA EQR	Asthma in Children and Younger Adults Admission Rate (Age 18–39 years)—Admission per 100,000 member months
PA EQR	Asthma in Children and Younger Adults Admission Rate (Total Age 2–39 years)—Admission per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years)—Admission per 100,000 member months

Source	Measures
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older)—Admission per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total 40+ years)—Admission per 100,000 member months
Comprehensive Diabetes Care	
HEDIS	Hemoglobin A1c (HbA1c) Testing
HEDIS	HbA1c Poor Control (> 9.0%)
HEDIS	HbA1c Control (< 8.0%)
HEDIS	HbA1c Good Control (< 7.0%)
HEDIS	Retinal Eye Exam
HEDIS	Medical Attention for Nephropathy
HEDIS	Blood Pressure Controlled < 140/90 mm Hg
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 18–64 years)—Admission per 100,000 member months
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 65+ years)—Admission per 100,000 member months
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Age 18+ years)—Admission per 100,000 member months
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 18–64 Years of Age)
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 65–75 Years of Age)
Cardiovascular Care	
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack
HEDIS	Controlling High Blood Pressure (Total Rate)
PA EQR	Heart Failure Admission Rate (Age 18–64 years)—Admission per 100,000 member months
PA EQR	Heart Failure Admission Rate (Age 65+ years)—Admission per 100,000 member months
PA EQR	Heart Failure Admission Rate (Total Age 18+ years)—Admission per 100,000 member months
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21–75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40–75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—21–75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—40–75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—Total Rate
HEDIS	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
Utilization	
PA EQR	Reducing Potentially Preventable Readmissions
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)

Source	Measures
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
HEDIS	Risk of Continued Opioid Use—New Episode Lasts at Least 31 Days
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)
HEDIS	Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS)—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed Readmission Rate—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Expected Readmission Rate—Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio—Total Stays (Ages Total)

PA-Specific Performance Measure Selection and Descriptions

Several PA-specific performance measures were calculated by each MCO and validated by IPRO. In accordance with DHS direction, IPRO created the indicator specifications to resemble HEDIS specifications. Measures previously developed and added, as mandated by CMS for children in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) and for adults in accordance with the Affordable Care Act (ACA), were continued as applicable to revised CMS specifications. Additionally, new measures were developed and added in 2020 as mandated in accordance with the ACA. 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 2020, PA-specific performance measure rates were calculated administratively, which uses only the MCOs data systems to identify numerator positives. The hybrid methodology, which uses a combination of administrative data and medical record review (MRR) to identify numerator "hits" for rate calculation, was not used for the 2020 PA-specific performance measures.

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 Administrative Measures

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

Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—CHIPRA Core Set
DHS enhanced this measure using behavioral health (BH) encounter data contained in IPRO's encounter data warehouse. IPRO evaluated this measure using HEDIS 2020 Medicaid member-level data submitted by the PH MCO.

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

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

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

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

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

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

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

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

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

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

Dental Sealants for 6- to 9-Year-Old Children at Elevated Caries Risk—CHIPRA Core Set
This performance measure assesses the percentage of enrolled children ages 6–9 years at elevated risk of dental caries who received a sealant on a permanent first molar tooth within the measurement year.

Additionally, to be more closely aligned to the CHIPRA Core Set Measure specifications, a second enhanced measure is reported that includes additional available dental data (Dental-enhanced).

Adult Annual Dental Visit ≥ 21 Years—PA-specific

This performance measure assesses the percentage of enrollees 21 years of age and above who were continuously enrolled during the calendar year 2019. 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.

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

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

Cesarean Rate for Nulliparous Singleton Vertex—CHIPRA Core Set
This performance measure assesses Cesarean Section Rate for low-risk first-birth women (aka, NSV CS rate: nulliparous, term, singleton, vertex).

Percent of Live Births Weighing Less than 2,500 Grams—CHIPRA Core Set
This performance measure is event-driven and identifies all live births during the measurement year in order to assess the number of live births that weighed less than 2,500 grams as a percent of the number of live births.

Elective Delivery—Adult Core Set
This performance measure assesses the percentage of enrolled women with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed.

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

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

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

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

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

Reducing Potentially Preventable Readmissions—PA-specific

This performance measure assesses the percentage of inpatient acute care discharges with subsequent readmission to inpatient acute care within 30 days of the initial inpatient acute discharge. This measure utilized the 2020 HEDIS Inpatient Utilization—General Hospital/Acute Care measure methodology to identify inpatient acute care discharges. For this measure, a lower rate indicates better performance.

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

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

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

Use of Pharmacotherapy for Opioid Use Disorder—Adult Core Set —New 2020
This performance measure assesses the percentage of members ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported: a total rate including any medications used in medication-assisted treatment of opioid dependence and addiction, and four separate rates representing the following FDA-approved drug products: (1) buprenorphine; (2) oral naltrexone; (3) long-acting, injectable naltrexone; and (4) methadone.

HEDIS Performance Measure Selection and Descriptions

Each MCO underwent a full HEDIS compliance audit in 2020. 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 2020, Volume 2 Narrative. The measurement year for HEDIS 2020 measures is 2019, 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 5.0—Child Survey.

Three measures – Appropriate Testing for Pharyngitis, Appropriate Treatment for Upper Respiratory Infection, and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis – are presented with their total rates. For each of these measures, additional age cohorts were included for HEDIS 2020. Per typical practice for first-year measures, rates for these additional age cohorts have not been included in this report.

Children and Adolescents' Access to Primary Care Practitioners
This measure assesses the percentage of members 12 months–19 years of age who had a visit with a PCP. Four separate percentages are reported for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

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

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

Well-Child Visits in the First 15 Months of Life
This measure assesses the percentage of members who turned 15 months old during the measurement year, who were continuously enrolled from 31 days of age through 15 months of age, and who received six or more well-child visits with a PCP during their first 15 months of life.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
This measure assesses the percentage of members 3–6 years of age, who were continuously enrolled during the measurement year, and who had one or more well-child visits with a PCP during the measurement year.

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

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

Adolescent Well-Care Visits
This measure assesses the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an ob/gyn practitioner during the measurement year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
This measure assesses the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. The measure is reported as an inverted rate (1 − [numerator/eligible population]). A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed). The total rate is reported.

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

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

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

Medication Management for People with Asthma—75% Compliance
This measure assesses the percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma, were dispensed appropriate medications that they remained on during the treatment period, and remained on an asthma controller medication for at least 75% of their treatment period. The following age groups are reported: 5–11 years, 12–18 years, 19–50 years, 51–64 years, and total years.

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%);
- HbA1c control (< 7.0%) for a selected population;
- Eye exam (retinal) performed;
- Medical attention for nephropathy; and
- BP control (< 140/90 mm Hg).

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

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

Persistence of Beta-Blocker Treatment After a Heart Attack

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

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

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

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

Total rates for both submeasures are also reported.

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

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

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

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

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

For this measure, a lower rate indicates better performance.

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

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

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

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

Pharmacotherapy for Opioid Use Disorder—New 2020
This measure assesses the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.

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

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

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

Implementation of PA-Specific Performance Measures and HEDIS Audit

The MCO successfully implemented all of the PA-specific measures for 2020 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures. As previously indicated, for each of the three PA Birth-related performance measures, IPRO utilized the MCO Birth files in addition to the 2020 Department of Health Birth File to identify the denominator, numerator, and rate.

In 2020, due to the COVID-19 pandemic, NCQA issued guidance that allowed plans to rotate HEDIS measures that are collected using the hybrid methodology. Plans were allowed to report their audited HEDIS 2019 hybrid rate for an applicable measure if it was better than their HEDIS 2020 hybrid rate due to low chart retrieval. DHS allowed MCOs to follow this guidance and because this could impact MCOs' reporting of the HEDIS Prenatal and Postpartum Care (PPC) measure, DHS suspended collection of the medical record review (MRR) PA performance measures that utilize the PPC sample. Therefore, for 2020, the Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit and Perinatal Depression Screening measures were not collected for 2020 (MY 2019).

Due to multiple implementation and validation issues that required additional follow-up over previous years for the Reducing Potentially Preventable Readmissions (RPR) measure, an attestation form was developed in 2019 to accompany the specifications. The attestation form listed the criteria for each review element in the measure. MCOs and, if applicable, their vendors were required to attest, or sign off, for each element, that the element was addressed in the source code used to create the data file submitted for validation. The attestation form was provided in addition to the requirements for MCOs to use the final specifications to collect the measure data, submit the source code used to produce the data file, and to pass validation of the data file. Completion of the form was required to complete validation and close out the measure. Additionally, oversight of vendors to comply with requirements is part of the MCOs' HealthChoices agreements. Because of this, during its implementation, DHS advised MCOs that the attestation form must be provided in addition to

all appropriate source code or a corrective action and/or financial sanction would be imposed. As MCOs began working with their vendors to complete the form, questions arose regarding the types of data that were being utilized as well as how they were being designated and utilized for the measure.

For GEI, the questions that arose during 2019 regarding data used for RPR were 1) how claims are unbundled for inclusion in the measure, 2) if claims assigned as denied by the MCO included only claims allowed per the specification (i.e., claims when services were rendered regardless of MCO non-payment), or if other claims not covered by the specifications would be assigned as denied and would therefore also be included in the measure, and 3) how interim billing is handled. For 2020, GEI noted that there was no change from 2019 and did not provide additional explanation. For bundling, GEI advised in 2019 that a report is sent to put members on hold where the provider submitted both admissions on one claims. GEI would pay the first claim and deny the second if they were separately billed. In 2019, for denied claims, GEI advised that the vendor includes denied claims, and GEI does not do anything additional to address denials. To address this, the MCO would need to work on a long-term solution include only the applicable denied. Re: interim billing in 2019, GEI responded that GEI denies claims with interim billing and only pays for inpatient claims. GEI worked as possible with the vendor to submit corrected files, source code, and completed attestation form to pass validation.

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

Findings

MCO results are presented in **Table 2.2** through **Table 2.11**. 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., 2020 [MY 2019] and 2019 [MY 2018]). In addition, statistical comparisons are made between the 2020 and 2019 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the *Z* ratio. A *Z* ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of 2020 rates to 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."

In addition to each individual MCO's rate, the MMC average for 2020 (MY 2019) 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 2020 rates to MMC rates, "+" denotes that the plan rate exceeds the MMC rate, "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

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

Table 2.5 to **Table 2.11** 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 2020 review year, but were also identified as opportunities in 2019.

- It is recommended that GEI focus on children's screening and follow-up, specifically re: Follow-up Care for Children Prescribed ADHD Medication. The Initiation Phase and Continuation Phase, as well as the BH Enhanced Initiation Phase and Continuation Phase were opportunities for improvement for 2020 and previously in 2019 for GEI.
- It is recommended that GEI focus on dental health for Annual Dental Visit for the Age 2-20 Year Cohort and Annual Dental Visits for Members with Developmental Disabilities for the Age 2-20 Year Cohort, as both were opportunities for improvement for GEI for 2020 and previously in 2019.
- It is recommended that GEI focus efforts on improving women's health matters across various measures. Chlamydia Screening in Women for Age 16-20, Age 21-24, and Total Age Cohorts, Contraceptive Care for Postpartum Women – Most or moderately effective contraception – 3 days for Age 15-20 and Age 21 to 44 Cohorts and also Contraceptive Care for Postpartum Women – Most or moderately effective contraception - 60 days for Age 21 to 44 were all opportunities for improvement in 2020 and 2019 for GEI. Furthermore, Contraceptive Care for Postpartum Women: LARC – 3 days and 60 days for Age 15-20 and also LARC – 60 days for Age 21-44 were all considered opportunities for improvement for GEI for 2020 and previously in 2019.
- It is recommended that GEI focus efforts on improving Diabetes Short-Term Complications Admission Rate/100,000 MM for both Age 18-64 and Age 18+ Year Cohorts as they were both opportunities for improvement in 2020 and 2019 for GEI.

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 2020 MMC weighted average:
  - Adults' Access to Preventive/Ambulatory Health Services (Age 20–44 years)—5.6 percentage points;
  - Adults' Access to Preventive/Ambulatory Health Services (Age 45–64 years)—3.4 percentage points;
  - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years)—4.7 percentage points;
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 12 to 17)—7.1 percentage points; and
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total age 1 to 17)—6.5 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

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12–24 months)	4,709	4,544	**96.5%**	96.0%	97.0%	97.0%	n.s.	96.9%	n.s.	≥ 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months–6 years)	19,944	18,239	**91.5%**	91.1%	91.8%	91.8%	n.s.	90.6%	+	≥ 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 7–11 years)	17,046	16,101	**94.5%**	94.1%	94.8%	94.9%	n.s.	93.2%	+	≥ 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12–19 years)	24,610	23,101	**93.9%**	93.6%	94.2%	94.4%	-	92.6%	+	≥ 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20–44 years)	46,173	38,874	**84.2%**	83.9%	84.5%	84.4%	n.s.	78.6%	+	≥ 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45–64 years)	24,148	21,497	**89.0%**	88.6%	89.4%	88.9%	n.s.	85.6%	+	≥ 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ years)	391	335	**85.7%**	82.1%	89.3%	87.4%	n.s.	80.9%	+	≥ 25th and < 50th percentile
HEDIS	Adult BMI Assessment (Age 18–74 years)	106	98	**92.5%**	87.0%	98.0%	92.5%	n.s.	95.3%	n.s.	≥ 50th and < 75th percentile

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 1 to 11)	195	149	**76.4%**	70.2%	82.6%	NA	NA	71.6%	n.s.	NA
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 17)	322	237	**73.6%**	68.6%	78.6%	71.5%	n.s.	66.5%	+	NA
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total age 1 to 17)	517	386	**74.7%**	70.8%	78.5%	74.1%	n.s.	68.2%	+	NA

Well-Care Visits and Immunizations

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

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

Table 2.3: Well-Care Visits and Immunizations

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (≥ 6 Visits)	321	238	**74.1%**	69.2%	79.1%	74.1%	n.s.	73.5%	n.s.	≥ 75th and < 90th percentile
HEDIS	Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (Age 3 to 6 years)	296	233	**78.7%**	73.9%	83.5%	77.1%	n.s.	79.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	Childhood Immunizations Status (Combination 2)	411	310	**75.4%**	71.1%	79.7%	75.4%	n.s.	76.4%	n.s.	≥ 50th and < 75th percentile
HEDIS	Childhood Immunizations Status (Combination 3)	411	296	**72.0%**	67.6%	76.5%	72.0%	n.s.	73.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	Adolescent Well-Care Visits (Age 12 to 21 Years)	395	241	**61.0%**	56.1%	65.9%	61.0%	n.s.	64.3%	n.s.	≥ 50th and < 75th percentile
HEDIS	Body Mass Index: Percentile (Age 3–11 years)	231	204	**88.3%**	84.0%	92.7%	88.3%	n.s.	85.0%	n.s.	≥ 75th and < 90th percentile
HEDIS	Body Mass Index: Percentile (Age 12–17 years)	145	125	**86.2%**	80.2%	92.2%	86.2%	n.s.	84.7%	n.s.	≥ 75th and < 90th percentile
HEDIS	Body Mass Index: Percentile (Total)	376	329	**87.5%**	84.0%	91.0%	87.5%	n.s.	84.9%	n.s.	≥ 75th and < 90th percentile
HEDIS	Counseling for Nutrition (Age 3–11 years)	231	176	**76.2%**	70.5%	81.9%	76.2%	n.s.	78.3%	n.s.	≥ 50th and < 75th percentile
HEDIS	Counseling for Nutrition (Age 12–17 years)	145	100	**69.0%**	61.1%	76.8%	69.0%	n.s.	75.5%	n.s.	≥ 25th and < 50th percentile
HEDIS	Counseling for Nutrition (Total)	376	276	**73.4%**	68.8%	78.0%	73.4%	n.s.	77.3%	n.s.	≥ 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Age 3–11 years)	231	153	**66.2%**	59.9%	72.5%	66.2%	n.s.	69.1%	n.s.	≥ 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Age 12–17 years)	145	102	**70.3%**	62.6%	78.1%	70.3%	n.s.	74.5%	n.s.	≥ 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Total)	376	255	**67.8%**	63.0%	72.7%	67.8%	n.s.	70.9%	n.s.	≥ 50th and < 75th percentile
HEDIS	Immunization for Adolescents (Combination 1)	411	370	**90.0%**	87.0%	93.0%	90.0%	n.s.	88.8%	n.s.	≥ 90th percentile

EPSDT: Screenings and Follow-up

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

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
  - Developmental Screening in the First Three Years of Life—Total—4.4 percentage points;
  - Developmental Screening in the First Three Years of Life—1 year—8.1 percentage points;
  - Developmental Screening in the First Three Years of Life—2 years—3.6 percentage points;
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Age: 18 to 64—ED visits for mental illness, follow-up within 7 days)—21.5 percentage points; and
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Age: 18 to 64—ED visits for mental illness, follow-up within 30 days)—18.1 percentage points.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
  - Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase—3.2 percentage points;
  - Follow-up Care for Children Prescribed ADHD Medication—Continuation Phase—9.7 percentage points;
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Initiation Phase—3.1 percentage points; and
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Continuation Phase—9.3 percentage points.

Table 2.4: EPSDT: Screenings and Follow-up

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Lead Screening in Children (Age 2 years)	411	338	**82.2%**	78.4%	86.1%	82.2%	n.s.	83.6%	n.s.	≥ 75th and < 90th percentile
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	1,105	449	**40.6%**	37.7%	43.6%	40.1%	n.s.	43.8%	-	≥ 25th and < 50th percentile
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Continuation Phase	399	166	**41.6%**	36.6%	46.6%	39.0%	n.s.	51.3%	-	≥ 10th and < 25th percentile
PA EQR	Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Initiation Phase	1,222	523	**42.8%**	40.0%	45.6%	41.4%	n.s.	45.9%	-	NA
PA EQR	Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced)—Continuation Phase	436	187	**42.9%**	38.1%	47.7%	43.8%	n.s.	52.2%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life—Total	12,704	8,307	**65.4%**	64.6%	66.2%	57.7%	+	61.0%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life—1 year	4,465	2,857	**64.0%**	62.6%	65.4%	54.6%	+	55.9%	+	NA

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
PA EQR	Developmental Screening in the First Three Years of Life—2 years	4,174	2,808	**67.3%**	65.8%	68.7%	59.9%	+	63.7%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life—3 years	4,065	2,642	**65.0%**	63.5%	66.5%	59.1%	+	63.6%	n.s.	NA
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 18 to 64—ED visits for mental illness, follow-up within 7 days)	958	586	**61.2%**	58.0%	64.3%	61.1%	n.s.	39.7%	+	NA
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 18 to 64—ED visits for mental illness, follow-up within 30 days)	958	677	**70.7%**	67.7%	73.6%	71.0%	n.s.	52.6%	+	NA
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 7 days)	976	173	**17.7%**	15.3%	20.2%	16.2%	n.s.	17.4%	n.s.	NA
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 18 to 64—ED visits for AOD abuse or dependence, follow-up within 30 days)	976	274	**28.1%**	25.2%	30.9%	26.2%	n.s.	27.3%	n.s.	NA
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 65 and older—ED visits for AOD abuse or dependence, follow-up within 30 days)	0	0	**NA**	NA	NA	NA	NA	6.9%	NA	NA

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 65 and older—ED visits for mental illness, follow-up within 30 days)	1	1	**NA**	NA	NA	NA	NA	100.0%	NA	NA
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 65 and older—ED visits for AOD abuse or dependence, follow-up within 7 days)	0	0	**NA**	NA	NA	NA	NA	3.5%	NA	NA
PA EQR	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Age: 65 and older—ED visits for mental illness, follow-up within 7 days)	1	0	**NA**	NA	NA	NA	NA	66.7%	NA	NA

Dental Care for Children and Adults

No strengths are identified for the Dental Care for Children and Adults performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
  - Annual Dental Visit (Age 2–20 years)—11.4 percentage points;
  - Annual Dental Visits for Members with Developmental Disabilities (Age 2–20years)—10.0 percentage points; and
  - Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—3.2 percentage points.

Table 2.5: EPSDT: Dental Care for Children and Adults

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Annual Dental Visit (Age 2–20 years)	69,979	38,062	**54.4%**	54.0%	54.8%	58.5%	-	65.8%	-	≥ 25th and < 50th percentile
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2–20 years)	5,145	2,793	**54.3%**	52.9%	55.7%	58.8%	-	64.3%	-	NA
PA EQR	Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	8,827	1,650	**18.7%**	17.9%	19.5%	28.4%	-	21.9%	-	NA
PA EQR	Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk (Dental Enhanced)	9,188	2,074	**22.6%**	21.7%	23.4%	25.3%	-	23.9%	-	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 21–35 years)	28,371	9,159	**32.3%**	31.7%	32.8%	33.9%	-	34.4%	-	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 36–59 years)	32,694	9,654	**29.5%**	29.0%	30.0%	31.9%	-	31.5%	-	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 60–64 years)	5,139	1,278	**24.9%**	23.7%	26.1%	27.2%	-	27.0%	-	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 65 years and older)	381	65	**17.1%**	13.2%	21.0%	17.5%	n.s.	19.9%	n.s.	NA
PA EQR	Adult Annual Dental Visit ≥ 21 Years (Age 21 years and older)	66,585	20,156	**30.3%**	29.9%	30.6%	32.3%	-	32.3%	-	NA

Women's Health

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

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
  - Breast Cancer Screening (Age 50–74 years)—3.2 percentage points; and
  - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Age 15 to 20)—5.3 percentage points.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
  - Chlamydia Screening in Women (Total)—7.2 percentage points;
  - Chlamydia Screening in Women (Age 16–20 years)—8.2 percentage points;
  - Chlamydia Screening in Women (Age 21–24 years)—5.8 percentage points;
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Age 15 to 20)—7.6 percentage points;
  - Contraceptive Care for Postpartum Women: LARC—3 days (Age 15 to 20)—6.4 percentage points;
  - Contraceptive Care for Postpartum Women: LARC—60 days (Age 15 to 20)—5.7 percentage points;
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Age 21 to 44)—10.0 percentage points;
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Age 21 to 44)—7.1 percentage points;
  - Contraceptive Care for Postpartum Women: LARC—3 days (Age 21 to 44)—4.0 percentage points; and
  - Contraceptive Care for Postpartum Women: LARC—60 days (Age 21 to 44)—5.3 percentage points.

Table 2.6: Women's Health

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Breast Cancer Screening (Age 50–74 years)	7,187	4,355	**60.6%**	59.5%	61.7%	59.8%	n.s.	57.4%	+	≥ 50th and < 75th percentile
HEDIS	Cervical Cancer Screening (Age 21–64 years)	395	254	**64.3%**	59.5%	69.2%	64.3%	n.s.	64.3%	n.s.	≥ 50th and < 75th percentile
HEDIS	Chlamydia Screening in Women (Total)	7,900	4,319	**54.7%**	53.6%	55.8%	55.1%	n.s.	61.9%	-	≥ 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Age 16–20 years)	4,443	2,231	**50.2%**	48.7%	51.7%	50.9%	n.s.	58.4%	-	≥ 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Age 21–-24 years)	3,457	2,088	**60.4%**	58.8%	62.0%	60.4%	n.s.	66.2%	-	≥ 25th and < 50th percentile
HEDIS	Non-Recommended Cervical Cancer Screening in Adolescent Females	7,422	148	**2.0%**	1.7%	2.3%	2.4%	n.s.	0.6%	+	< 10th percentile

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Age 15 to 20)	8,765	3,369	**38.4%**	37.4%	39.5%	37.9%	n.s.	33.1%	+	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Age 15 to 20)	8,765	311	**3.5%**	3.2%	3.9%	3.0%	+	4.0%	-	NA
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Age 21 to 44)	26,210	7,773	**29.7%**	29.1%	30.2%	29.5%	n.s.	28.6%	+	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Age 21 to 44)	26,210	1,157	**4.4%**	4.2%	4.7%	4.1%	+	4.6%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Age 15 to 20)	310	15	**4.8%**	2.3%	7.4%	5.8%	n.s.	12.4%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Age 15 to 20)	310	140	**45.2%**	39.5%	50.9%	42.1%	n.s.	46.2%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Age 15 to 20)	310	2	**0.6%**	0.0%	1.7%	0.6%	n.s.	7.0%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Age 15 to 20)	310	32	**10.3%**	6.8%	13.9%	7.8%	n.s.	16.0%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—3 days (Age 21 to 44)	2,645	181	**6.8%**	5.9%	7.8%	9.2%	-	16.8%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception—60 days (Age 21 to 44)	2,645	983	**37.2%**	35.3%	39.0%	37.8%	n.s.	44.3%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—3 days (Age 21 to 44)	2,645	12	**0.5%**	0.2%	0.7%	0.4%	n.s.	4.4%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC—60 days (Age 21 to 44)	2,645	183	**6.9%**	5.9%	7.9%	6.6%	n.s.	12.2%	-	NA

[1] For the Non-Recommended Cervical Cancer Screening in Adolescent Females measure, lower rate indicates better performance.

Obstetric and Neonatal Care

No strengths are identified for the Obstetric and Neonatal Care performance measures.

Opportunities for improvement are identified for the following performance measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
  - Cesarean Rate for Nulliparous Singleton Vertex—3.2 percentage points.

Table 2.7: Obstetric and Neonatal Care

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Prenatal and Postpartum Care—Timeliness of Prenatal Care	411	377	**91.7%**	88.9%	94.5%	85.2%	+	91.7%	n.s.	≥ 50th and < 75th percentile
HEDIS	Prenatal and Postpartum Care—Postpartum Care	411	337	**82.0%**	78.2%	85.8%	68.6%	+	79.3%	n.s.	≥ 75th and < 90th percentile
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	796	206	**25.9%**	22.8%	29.0%	24.7%	n.s.	22.7%	+	NA
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	3,850	285	**7.4%**	6.6%	8.2%	7.7%	n.s.	8.8%	-	NA
PA EQR	Elective Delivery	939	157	**16.7%**	14.3%	19.2%	17.5%	n.s.	15.3%	n.s.	NA

[1] Lower rate indicates better performance for three measures that are related to live births: Cesarean Rate for Nulliparous Singleton Vertex, Percent of Live Births Weighing Less than 2,500 Grams (Positive), and Elective Delivery.

Respiratory Conditions

Strengths are identified for the following Respiratory Conditions performance measures:

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
  - Medication Management for People with Asthma—75% Compliance (Age 5–11 years)—13.0 percentage points;
  - Medication Management for People with Asthma—75% Compliance (Age 12–18 years)—4.5 percentage points;
  - Medication Management for People with Asthma—75% Compliance (Age 19–50 years)—7.7 percentage points;
  - Medication Management for People with Asthma—75% Compliance (Age 51–64 years)—9.7 percentage points;
  - Medication Management for People with Asthma—75% Compliance (Total—Age 5–64 years)—8.6 percentage points;
  - Asthma Medication Ratio (5–11 years)—12.0 percentage points;
  - Asthma Medication Ratio (12–18 years)—5.8 percentage points;
  - Asthma Medication Ratio (19–50 years)—4.1 percentage points;
  - Asthma Medication Ratio (Total)—4.7 percentage points;
  - Asthma in Younger Adults Admission Rate (Age 2–17 years) per 100,000 member months—10.14 admissions per 100,000 member months;
  - Asthma in Younger Adults Admission Rate (Age 18–39 years) per 100,000 member months—3.94 admissions per 100,000 member months;
  - Asthma in Younger Adults Admission Rate (Total Age 2–39 years) per 100,000 member months—7.32 admissions per 100,000 member months;
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months—21.25 admissions per 100,000 member months; and
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months—20.36 admissions per 100,000 member months.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
  - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator—3.1 percentage points.

Table 2.8: Respiratory Conditions

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Appropriate Testing for Pharyngitis (Total—Age 3 years and older)	11,204	8,254	**73.7%**	72.9%	74.5%	80.4%	-	75.6%	-	≥ 25th and < 50th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Total—Age 3 months and older)	26,746	3,393	**87.3%**	86.9%	87.7%	89.9%	-	89.6%	-	≥ 25th and < 50th percentile
HEDIS	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total—Age 3 months and older)	4,604	2,130	**53.7%**	52.3%	55.2%	44.7%	+	56.5%	-	≥ 50th and < 75th percentile

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	838	240	**28.6%**	25.5%	31.8%	28.6%	n.s.	28.9%	n.s.	≥ 25th and < 50th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	689	529	**76.8%**	73.6%	80.0%	77.5%	n.s.	77.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	689	578	**83.9%**	81.1%	86.7%	88.3%	-	86.9%	-	≥ 25th and < 50th percentile
HEDIS	Medication Management for People with Asthma—75% Compliance (Age 5–11 years)	615	328	**53.3%**	49.3%	57.4%	47.0%	+	40.3%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma—75% Compliance (Age 12–18 years)	657	306	**46.6%**	42.7%	50.5%	43.9%	n.s.	42.1%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma—75% Compliance (Age 19–50 years)	1,194	649	**54.4%**	51.5%	57.2%	52.4%	n.s.	46.6%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma—75% Compliance (Age 51–64 years)	295	204	**69.2%**	63.7%	74.6%	69.2%	n.s.	59.5%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma—75% Compliance (Total—Age 5–64 years)	2,761	1,487	**53.9%**	52.0%	55.7%	51.2%	+	45.3%	+	≥ 90th percentile
HEDIS	Asthma Medication Ratio (5–11 years)	672	561	**83.5%**	80.6%	86.4%	82.8%	n.s.	71.5%	+	≥ 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (12–18 years)	745	545	**73.2%**	69.9%	76.4%	73.8%	n.s.	67.3%	+	≥ 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (19–50 years)	1,528	906	**59.3%**	56.8%	61.8%	62.1%	n.s.	55.2%	+	≥ 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (51–64 years)	401	241	**60.1%**	55.2%	65.0%	60.8%	n.s.	58.4%	n.s.	≥ 75th and < 90th percentile

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Asthma Medication Ratio (Total)	3,346	2,253	**67.3%**	65.7%	68.9%	68.6%	n.s.	62.7%	+	≥ 50th and < 75th percentile
PA EQR	Asthma in Children and Younger Adults Admission Rate (Age 2–17 years) per 100,000 member months	818,753	41	**5.0**	3.5	6.5	NA	NA	15.1	-	NA
PA EQR	Asthma in Children and Younger Adults Admission Rate (Age 18–39 years) per 100,000 member months	678,338	28	**4.1**	2.6	5.7	9.0	-	8.1	-	NA
PA EQR	Asthma in Children and Younger Adults Admission Rate (Total Age 2–39 years) per 100,000 member months	1,497,091	69	**4.6**	3.5	5.7	NA	NA	11.9	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months	445,669	171	**38.4**	32.6	44.1	59.7	-	59.6	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months	5,665	5	**88.3**	10.9	165.6	35.7	n.s.	46.8	n.s.	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months	451,334	176	**39.0**	33.2	44.8	59.4	-	59.4	-	NA

[1] Per NCQA, a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

[2] Per NCQA, a higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

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

Comprehensive Diabetes Care

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

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
  - Retinal Eye Exam—6.5 percentage points;
  - Blood Pressure Controlled < 140/90 mm Hg—8.3 percentage points;
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 18–64 Years of Age)—6.6 percentage points; and
  - HbA1c Poor Control (> 9.0%)—4.5 percentage points.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
  - Diabetes Short-Term Complications Admission Rate (Age 18–64 years) per 100,000 member months—4.96 admissions per 100,000 member months; and
  - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months—4.99 admissions per 100,000 member months.

Table 2.9: Comprehensive Diabetes Care

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Hemoglobin A1c (HbA1c) Testing	556	484	**87.1%**	84.2%	89.9%	87.1%	n.s.	87.6%	n.s.	≥ 25th and < 50th percentile
HEDIS	HbA1c Poor Control (> 9.0%)	556	162	**29.1%**	25.3%	33.0%	29.1%	n.s.	33.7%	-	≥ 75th and < 90th percentile
HEDIS	HbA1c Control (< 8.0%)	556	324	**58.3%**	54.1%	62.5%	58.3%	n.s.	54.5%	n.s.	≥ 75th and < 90th percentile
HEDIS	HbA1c Good Control (< 7.0%)	411	157	**38.2%**	33.4%	43.0%	38.2%	n.s.	40.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Retinal Eye Exam	556	370	**66.5%**	62.5%	70.6%	66.5%	n.s.	60.0%	+	≥ 75th and < 90th percentile
HEDIS	Medical Attention for Nephropathy	556	499	**89.7%**	87.1%	92.4%	89.7%	n.s.	89.8%	n.s.	≥ 25th and < 50th percentile
HEDIS	Blood Pressure Controlled < 140/90 mm Hg	556	439	**79.0%**	75.5%	82.4%	79.0%	n.s.	70.7%	+	≥ 90th percentile

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 18–64 years) per 100,000 member months	1,124,007	321	**28.6**	25.4	31.7	26.3	n.s.	23.6	+	NA
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 65+ years) per 100,000 member months	5,665	0	**0.0**	0.0	0.0	0.0	NA	2.7	n.s.	NA
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months	1,129,672	321	**28.4**	25.3	31.5	26.2	n.s.	23.4	+	NA
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy	3,882	2,642	**68.1%**	66.6%	69.5%	66.0%	n.s.	69.1%	n.s.	≥ 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%	2,642	1,884	**71.3%**	69.6%	73.1%	67.6%	+	69.6%	n.s.	≥ 75th and < 90th percentile
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 18–64 Years of Age)	735	661	**89.9%**	87.7%	92.2%	90.0%	n.s.	83.3%	+	NA
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (Age Cohort: 65–75 Years of Age)	1	1	**NA**	NA	NA	NA	NA	85.1%	NA	NA

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

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

Cardiovascular Care

Strengths are identified for the following Cardiovascular Care performance measures:

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21–75 years (Male)—3.4 percentage points;
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40–75 years (Female)—4.7 percentage points;
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate—3.9 percentage points;
  - Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—Total Rate—3.2 percentage points; and
  - Heart Failure Admission Rate (Age 18–64 years) per 100,000 member months—2.71 admissions per 100,000 member months.

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

Table 2.10: Cardiovascular Care

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack	126	115	**91.3%**	85.9%	96.6%	80.5%	+	86.6%	n.s.	≥ 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	411	295	**71.8%**	67.3%	76.2%	71.8%	n.s.	68.3%	n.s.	≥ 75th and < 90th percentile
PA EQR	Heart Failure Admission Rate (Age 18–64 years) per 100,000 member months	1,124,007	193	**17.2**	14.7	19.6	18.2	n.s.	19.9	-	NA
PA EQR	Heart Failure Admission Rate (Age 65+ years) per 100,000 member months	5,665	8	**141.2**	43.4	239.1	107.0	n.s.	76.5	n.s.	NA
PA EQR	Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months	1,129,672	201	**17.8**	15.3	20.3	18.6	n.s.	20.3	n.s.	NA
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21–75 years (Male)	706	622	**88.1%**	85.6%	90.6%	81.7%	+	84.7%	+	≥ 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40–75 years (Female)	513	443	**86.4%**	83.3%	89.4%	83.6%	n.s.	81.7%	+	≥ 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate	1,219	1,065	**87.4%**	85.5%	89.3%	82.6%	+	83.4%	+	≥ 90th percentile

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—21–75 years (Male)	622	471	**75.7%**	72.3%	79.2%	70.7%	+	72.0%	n.s.	≥ 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—40–75 years (Female)	443	334	**75.4%**	71.3%	79.5%	67.5%	+	72.9%	n.s.	≥ 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80%—Total Rate	1,065	805	**75.6%**	73.0%	78.2%	69.3%	+	72.4%	+	≥ 75th and < 90th percentile
HEDIS	Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia	11	10	**NA**	NA	NA	NA	NA	78.9%	NA	≥ 90th percentile

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

Utilization

Strengths are identified for the following Utilization performance measures:

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Age 1–11 years)—5.1 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Age 12–17 years)—3.6 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Age 1–17 years)—4.0 percentage points;
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Age 1–11 years)—5.5 percentage points;
  - Pharmacotherapy for Opioid Use Disorder (Age 16–64 years)—14.4 percentage points;
  - Pharmacotherapy for Opioid Use Disorder (Total Age 16+ years)—14.4 percentage points;
  - Use of Pharmacotherapy for Opioid Use Disorder (Total)—4.8 percentage points; and
  - Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)—7.7 percentage points.

Opportunities for improvement are identified for the following performance measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
  - Use of Opioids From Multiple Providers (4 or more prescribers)—3.2 percentage points.

Table 2.11: Utilization

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
PA EQR	Reducing Potentially Preventable Readmissions	12,045	1,234	**10.2%**	9.7%	10.8%	9.4%	+	11.3%	-	NA
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	404	264	**65.3%**	60.6%	70.1%	69.4%	n.s.	65.7%	n.s.	≥ 50th and < 75th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	712	498	**69.9%**	66.5%	73.4%	82.0%	-	69.3%	n.s.	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Age 1–11 years)	554	449	**81.0%**	77.7%	84.4%	NA	NA	75.9%	+	≥ 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Age 12–17 years)	982	822	**83.7%**	81.3%	86.1%	NA	NA	80.1%	+	≥ 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Age 1–17 years)	1,536	1,271	**82.7%**	80.8%	84.7%	NA	NA	78.8%	+	≥ 90th percentile

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Age 1–11 years)	554	425	**76.7%**	73.1%	80.3%	NA	NA	72.9%	n.s.	≥ 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Age 12–17 years)	982	681	**69.3%**	66.4%	72.3%	NA	NA	69.8%	n.s.	≥ 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Age 1–17 years)	1,536	1,106	**72.0%**	69.7%	74.3%	NA	NA	70.9%	n.s.	≥ 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Age 1–11 years)	554	412	**74.4%**	70.6%	78.1%	NA	NA	68.9%	+	≥ 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Age 12–17 years)	982	679	**69.1%**	66.2%	72.1%	NA	NA	68.2%	n.s.	≥ 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Age 1–17 years)	1,536	1,091	**71.0%**	68.7%	73.3%	NA	NA	68.5%	+	≥ 90th percentile
HEDIS	Use of Opioids at High Dosage	2,821	218	**7.7%**	6.7%	8.7%	4.2%	+	9.4%	-	≥ 25th and < 50th percentile
HEDIS	Use of Opioids from Multiple Providers (4 or more prescribers)	3,489	614	**17.6%**	16.3%	18.9%	16.7%	n.s.	14.4%	+	≥ 50th and < 75th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more pharmacies)	3,489	49	**1.4%**	1.0%	1.8%	2.0%	-	2.6%	-	≥ 90th percentile
HEDIS	Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)	3,489	30	**0.9%**	0.5%	1.2%	0.8%	n.s.	1.2%	n.s.	≥ 75th and < 90th percentile
HEDIS	Risk of Continued Opioid Use - New Episode Lasts at Least 15 Days	10,127	419	**4.1%**	3.7%	4.5%	6.2%	-	4.0%	n.s.	≥ 50th and < 75th percentile
HEDIS	Risk of Continued Opioid Use - New Episode Lasts at Least 31 Days	10,127	193	**1.9%**	1.6%	2.2%	2.8%	-	2.4%	-	≥ 75th and < 90th percentile
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Age 18–64 years)	3,157	655	**20.7%**	19.3%	22.2%	25.2%	-	18.9%	+	NA

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Age 65 years and older)	7	5	**NA**	NA	NA	NA	NA	16.1%	n.s.	NA
PA EQR	Concurrent Use of Opioids and Benzodiazepines (Total Age 18 years and older)	3,164	660	**20.9%**	19.4%	22.3%	25.2%	-	18.9%	+	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (Age 16–64 years)	1,604	654	**40.8%**	38.3%	43.2%	NA	NA	26.4%	+	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (Age 65+ years)	1	1	**NA**	NA	NA	NA	NA	NA	n.s.	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (Total Age 16+ years)	1,605	655	**40.8%**	38.4%	43.2%	NA	NA	26.4%	+	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Total)	629	466	**74.1%**	70.6%	77.6%	NA	NA	69.3%	+	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)	629	442	**70.3%**	66.6%	73.9%	NA	NA	62.6%	+	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Oral Naltrexone)	629	18	**2.9%**	1.5%	4.2%	NA	NA	4.3%	n.s.	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Long-Acting, Injectable Naltrexone)	629	30	**4.8%**	3.0%	6.5%	NA	NA	7.5%	-	NA
PA EQR	Use of Pharmacotherapy for Opioid Use Disorder (Methadone)	629	0	**0.0%**	0.0%	0.1%	NA	NA	1.8%	-	NA

		2020 (MY 2019)					2020 (MY 2019) Rate Comparison				
Indicator Source	Indicator		Count	Rate			2019 (MY 2018) Rate	2020 Rate Compared to 2019			HEDIS 2020 Percentile
HEDIS	PCR: Count of Index Hospital Stays (IHS)—Total Stays (Age Total)		4,543				4,954				NA
HEDIS	PCR: Count of 30-Day Readmissions—Total Stays (Age Total)		494				559				NA
HEDIS	PCR: Observed Readmission Rate—Total Stays (Age Total)			**10.9%**			11.3%	NA			NA
HEDIS	PCR: Expected Readmission Rate—Total Stays (Age Total)			**10.1%**			18.5%	NA			NA

HEDIS	PCR: Observed to Expected Readmission Ratio—Total Stays (Age Total)			**107.9%**			61.1%	NA			NA

[1] For the Reducing Potentially Preventable Readmissions measure, lower rates indicate better performance.
[2] For the Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure, lower rates indicate better performance.
[3] For the Plan All-Cause Readmissions (PCR) measure, cells that are shaded are data elements that are not relevant to the measure.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

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

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

2020 Adult CAHPS 5.0H Survey Results

Table 2.12: CAHPS 2020 Adult Survey Results

Survey Section/Measure	2020 (MY 2019)	2020 Rate Compared to 2019	2019 (MY 2018)	2019 Rate Compared to 2018	2018 (MY 2017)	2020 MMC Weighted Average
Your Health Plan						
Satisfaction with Adult's Health Plan (Rating of 8–10)	83.72%	▲	82.64%	▲	81.72%	81.71%
Getting Needed Information (Usually or Always)	91.59%	▲	91.46%	▲	82.95%	85.33%
Your Healthcare in the Last 6 Months						
Satisfaction with Health Care (Rating of 8–10)	79.70%	▲	74.12%	▼	74.79%	78.18%
Appointment for Routine Care When Needed (Usually or Always)	78.97%	▼	86.73%	▲	81.74%	81.80%

▲▼ = Performance compared to prior years' rates.
Shaded boxes reflect rates above the 2020 MMC Weighted Average.

2020 Child CAHPS 5.0H Survey Results

Table 2.13: CAHPS 2020 Child Survey Results

CAHPS Items	2020 (MY 2019)	2020 Rate Compared to 2019	2019 (MY 2018)	2019 Rate Compared to 2018	2018 (MY 2017)	2020 MMC Weighted Average
Your Child's Health Plan						
Satisfaction with Child's Health Plan (Rating of 8–10)	89.75%	▲	89.21%	▲	87.75%	89.40%
Information or Help from Customer Service (Usually or Always)	89.39%	▲	82.95%	▼	87.23%	85.26%
Your Healthcare in the Last 6 Months						
Satisfaction with Health Care (Rating of 8–10)	87.50%	▲	86.74%	▲	83.68%	88.52%
Appointment for Routine Care When Needed (Usually or Always)	92.51%	▲	86.91%	▼	92.06%	89.87%

▲▼ = Performance compared to prior years' rates.
Shaded boxes reflect rates above the 2020 MMC Weighted Average.

III: Structure and Operations Standards

This section of the EQR report presents a review by IPRO of GEI's compliance with structure and operations standards. The review is based on information derived from reviews of the MCO that were conducted within the past three years.

Methodology and Format

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, 2019, additional monitoring activities outlined by DHS staff, and the most recent NCQA Accreditation Survey for GEI, effective December 2019.

The SMART items provided much of the information necessary for this review. The SMART items are a comprehensive set of monitoring items that PA DHS staff reviews on an ongoing basis for each Medicaid MCO. 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. In 2018, upon receipt of the findings for RY 2017, IPRO and DHS discussed changes to the information included. First, the only available review conclusions were Compliant and non-Compliant. All other options previously available were re-designated in RY 2017 from review conclusion elements to review status elements and were therefore not included in the RY 2017 findings. Additionally, as of RY 2017, reviewers had 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 RY 2017. These changes remained for the findings received in 2020. Upon review of the data elements from each version of database, IPRO merged the RY 2019, 2018, and 2017 findings for use in the current review. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 126 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS.

The crosswalk linked SMART Items to specific provisions of the regulations, where possible. Some items were relevant to more than one provision. It should be noted that the compliance evaluation was conducted on the crosswalked regulations as indicated above. However, the revised CMS protocols include updates to the structure and compliance standards, including which standards are required for compliance review. Under the new protocols, there are 11 standards that CMS has now designated as required to be subject to compliance review. Several previously required standards have now 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. To accommodate this change, this section will 1) outline the compliance evaluation as conducted with standards prior to the updates, and 2) incorporate discussion of the updates.

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 2019, 2018, and 2017), which incorporates both the prior and the new set of EQR protocols. Further, the CMS protocol updates are reflected in **Table 3.1**: 1) regulation/subpart names have been updated as applicable, 2) a *Required* column has been included to indicate the 11 standards that CMS has now designated as subject to compliance review, and 3) a *Related* column has been included to indicate standards that CMS has now deemed as incorporated into the compliance review through interaction with the required standards.

Table 3.1: SMART Items Count Per Regulation

BBA Regulation	SMART Items	Required	Related
Subpart C: Enrollee Rights and Protections			
Enrollee Rights	7		✓
Provider-Enrollee Communication	1		✓
Marketing Activities	2		✓
Liability for Payment	1		
Cost Sharing	0		
Emergency and Post-Stabilization Services – Definition	4		✓
Emergency Services: Coverage and Payment	1		✓
Solvency Standards	2		
Subpart D: MCO, PIHP and PAHP Standards			

BBA Regulation	SMART Items	Required	Related
Availability of Services	14	✓	
Assurances of adequate capacity and services	3*	✓	
Coordination and Continuity of Care	13	✓	
Coverage and Authorization of Services	9	✓	
Provider Selection	4	✓	
Provider Discrimination Prohibited	1		✓
Confidentiality	1	✓	
Enrollment and Disenrollment	2		✓
Grievance and appeal Systems	1	✓	
Subcontractual Relationships and Delegations	3	✓	
Practice Guidelines	2	✓	
Health Information Systems	18	✓	
Subpart E: Quality Measurement and Improvement; External Quality Review			
Quality assessment and performance improvement program (QAPI)	9*	✓	
Subpart F: Grievance and Appeal System			
General Requirements	8		✓
Notice of Action	3		✓
Handling of Grievances and Appeals	9		✓
Resolution and Notification	7		✓
Expedited Resolution	4		✓
Information to Providers and Subcontractors	1		✓
Recordkeeping and Recording	6		✓
Continuation of Benefits Pending Appeal and State Fair Hearings	2		✓
Effectuation of Reversed Resolutions	0		✓

* Additional SMART Items that were identified as applicable for the updated protocols. These SMART Items are not included in the current crosswalk and are not part of the original total number of crosswalked items.

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 Agreements. 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.

Two categories in the updated protocols, Assurances of adequate capacity and services and Quality assessment and performance improvement program, were not addressed by SMART Items in the current crosswalk. The elements in these standards are currently assessed via various mechanisms throughout the HealthChoices program. Some additional SMART standards are used, together with MCO contract agreements, department policies and procedures, and EQR requirements for the MCOs. DHS is currently reassessing the items in its review tool and SMART system to better align them with the updated standards, and is working towards a more direct and streamlined method of assessing and summarizing compliance for each MCO. For the current review year, additional information regarding the mechanisms used to address each of these categories is provided below.

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. For activities going forward, DHS is in process of developing SMART standards to ensure compliance with network adequacy for 2021 and more directly encompass requirements outlined in 42 C.F.R. §438.207 subsections (a) – (e).

Review of the Quality assessment and performance improvement program standard included nine additional SMART Items that reference multiple requirements related to quality management and assessment, performance improvement, utilization management, and external quality review. Each of these items cites specific requirements outlined in the HealthChoices agreement, against which MCOs are assessed. Additionally, and more specifically related to performance improvement projects, DHS cited the validation process the MCOs are required to undergo annually as well as the requirements within 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. The MCO is advised to work with DHS to fully understand DHS' review findings for any non-Compliant items and plan for correction.

Format

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the subparts set out in the BBA regulations and described in the CMS EQR Protocol: *Review of Compliance with Medicaid and CHIP Managed Care Regulations*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. As noted, IPRO's findings are presented in a manner consistent with the subparts in the BBA regulations prior to 2019. However, findings will be further discussed relative to applicable subparts as indicated in the revised Protocol, i.e., Subpart D – MCO, PIHP and PAHP Standards and Subpart E – Quality Measurement and Improvement.

In addition to this analysis of DHS's MCO compliance monitoring, IPRO reviewed and evaluated the most recent NCQA accreditation report for each MCO.

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 126 SMART Items, 77 items were evaluated and 49 were not evaluated for the MCO in RY 2019, RY 2018, or RY 2017. For categories where items were not evaluated for compliance for RY 2019, results from reviews conducted within the two prior years (RY 2018 and RY 2017) were evaluated to determine compliance, if available.

Subpart C: Enrollee Rights and Protections

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

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

Table 3.2: GEI Compliance with Enrollee Rights and Protections Regulations

ENROLLEE RIGHTS AND PROTECTIONS REGULATIONS		
Subpart C: Categories	**Compliance**	**Comments**
Enrollee Rights	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 6 items and was compliant on 6 items based on RY 2019.
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 2019.
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 2019.
Liability for 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 2019.
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 2019.
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 2019.
Solvency Standards	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2019.

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

Subpart D: MCO, PIHP and PAHP Standards

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

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

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

MCO, PIHP AND PAHP STANDARDS REGULATIONS		
Subpart D: Categories	**Compliance**	**Comments**
Availability of Services	Compliant	14 items were crosswalked to this category. The MCO was evaluated against 10 items and was compliant on 10 items based on RY 2019.
Assurances of Adequate Capacity and Services	Compliant	This category was evaluated against additional SMART Items and DHS monitoring activities.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 11 items and was compliant on 11 items based on RY 2019.
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 2019.
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 2019.
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 2019.
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 2019.
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 2019.
Grievance and Appeal Systems	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.
Subcontractual Relationships and Delegations	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2019.
Practice Guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on 1 item based on RY 2019.
Health Information Systems	Partially Compliant	18 items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on 11 items and non-compliant on 1 item based on RY 2019.

GEI was evaluated against 49 of 68 SMART Items that were crosswalked to MCO, PIHP and PAHP Standards Regulations and was compliant on 48 items and non-compliant on 1 item. Of the 12 categories in MCO, PIHP and PAHP Standards, GEI was found to be compliant on 11 categories and partially compliant on 1 category, Health Information Systems. Within this category, GEI was non-compliant on SMART standard A/F 13.7.

Subpart E: Quality Measurement and Improvement; External Quality Review

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

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

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

QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW REGULATIONS		
Subpart E: Categories	**Compliance**	**Comments**
Quality Assessment and Performance Improvement Program (QAPI)	Compliant	This category was evaluated against additional SMART Items and DHS monitoring activities.

GEI was found to be compliant for the category within Quality Measurement and Improvement; External Quality Review.

Subpart F: Grievance and Appeal System

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

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

Table 3.5: GEI Compliance with Grievance and Appeal System Regulations

GRIEVANCE AND APPEAL SYSTEM REGULATIONS		
Subpart F: Categories	**Compliance**	**Comments**
General Requirements	Compliant	8 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.
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 2019.
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 2019.
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 2019.
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 2019.
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 2019.
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 2019.

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 2019.
Effectuation of Reversed Resolutions	Compliant	Per NCQA Accreditation, 2019

GEI was evaluated against 13 of the 40 SMART Items crosswalked to Grievance and Appeal System and was compliant on all 13 items. GEI was found to be compliant for all nine categories of Grievance and Appeal System.

Accreditation Status

GEI underwent an NCQA Accreditation Survey effective through December 14, 2021 and was granted an Accreditation Status of Commendable.

IV: 2019 Opportunities for Improvement MCO Response

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 2019 EQR Technical Reports, which were distributed June 2020. The 20120 EQR is the twelfth to include descriptions of current and proposed interventions from each PH MCO that address the 2019 recommendations.

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

- Follow-up actions that the MCO has taken through June 30, 2020 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 2020, as well as any additional relevant documentation provided by GEI. Following review of GEI's response, the MCO was asked to provide additional information regarding follow-up activities for select measures. GEI submitted updated responses.

The embedded Word document presents GEI's responses to opportunities for improvement cited by IPRO in the 2019 EQR Technical Report, detailing current and proposed interventions. The measures that required responses include the following:

- Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase
- Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase
- Annual Dental Visit (Age 2–20 years)
- Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years)
- Chlamydia Screening in Women (Total, Age 16-20 years, and Age 21-24 years)
- Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20)
- Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20)
- Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)
- Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 21 to 44)
- Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)
- Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44)
- Prenatal Counseling for Depression
- Elective Delivery
- Appropriate Testing for Children with Pharyngitis
- Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months
- Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months

GEI 2019 Current and Proposed Interve

Root Cause Analysis and Action Plan

The 2020 EQR is the eleventh year MCOs were required to prepare a Root Cause Analysis and Action Plan for measures on the HEDIS 2019 P4P Measure Matrix receiving either "D" or "F" ratings. Each P4P measure in categories "D" and "F" required that the MCO submit:

- A goal statement;
- Root cause analysis and analysis findings;

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

For the 2020 EQR, GEI was not required to prepare a Root Cause Analysis and Action Plan, as all of the measures scored a rating of “C” or above on the HEDIS 2019 P4P Measure Matrix.

V: 2020 Strengths and Opportunities for Improvement

The review of MCO's 2020 performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for Medicaid members served by this MCO.

For 2020, in light of the COVID-19 global health crisis, NCQA allowed plans to rotate HEDIS measures that are collected using the hybrid methodology. Plans were allowed to report their audited HEDIS 2019 hybrid rate for an applicable measure if it was better than their HEDIS 2020 hybrid rate as a result of low chart retrieval. Due to this, some strengths and opportunities that were identified in 2019 may be identified for the MCO again for 2020, and may again require review and response.

Strengths

- GEI was found to be fully compliant on Subparts C and F of the structure and operations standards.

- For approximately 25 percent of reported measures, the MCO's performance was statistically significantly above/better than the MMC weighted average in 2020 (MY 2019) on the following measures:
    - Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years)
    - Adults' Access to Preventive/Ambulatory Health Services (Age 45-64 years)
    - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)
    - 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
    - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days)
    - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days)
    - Breast Cancer Screening (Age 50-74 years)
    - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)
    - Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)
    - Medication Management for People with Asthma - 75% Compliance (Age 12-18 years)
    - Medication Management for People with Asthma - 75% Compliance (Age 19-50 years)
    - Medication Management for People with Asthma - 75% Compliance (Age 51-64 years)
    - Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years)
    - Asthma Medication Ratio (5-11 years)
    - Asthma Medication Ratio (12-18 years)
    - Asthma Medication Ratio (19-50 years)
    - Asthma Medication Ratio (Total)
    - Asthma in Younger Adults Admission Rate (Age 2-17 years) per 100,000 member months
    - Asthma in Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months
    - Asthma in Younger Adults Admission Rate (Total Age 2-39 years) per 100,000 member months
    - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months
    - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months
    - 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)
    - HbA1c Poor Control (>9.0%)
    - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21-75 years (Male)

- Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female)
- Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate
- Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate
- Heart Failure Admission Rate (Age 18-64 years) 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: Blood Glucose & Cholesterol Testing (Ages 1-11 years)
- Pharmacotherapy for Opioid Use Disorder (Ages 16-64 years)
- Pharmacotherapy for Opioid Use Disorder (Total Ages 16+ years)
- Use of Pharmacotherapy for Opioid Use Disorder (Total)
- Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)

- The following strengths were noted in 2020 (MY 2019) for Adult and child CAHPS survey items:
  - Of the four Adult CAHPS composite survey items reviewed, three items were above the 2020 MMC weighted average. Three items increased in 2020 (MY 2019) as compared to 2019 (MY 2018).
  - Of the four Child CAHPS composite survey items reviewed, three items were above the 2020 MMC weighted average. All items increased in 2020 (MY 2019) as compared to 2019 (MY 2018).

Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC weighted average in 2020 (MY 2019) on the following measures:
  - Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase
  - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase
  - Annual Dental Visit (Age 2–20 years)
  - Annual Dental Visits for Members with Developmental Disabilities (Age 2-20years)
  - Dental Sealants for 6-9 Year Old Children At Elevated Caries Risk
  - Chlamydia Screening in Women (Total)
  - Chlamydia Screening in Women (Age 16-20 years)
  - Chlamydia Screening in Women (Age 21-24 years)
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 21 to 44)
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21 to 44)
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44)
  - Cesarean Rate for Nulliparous Singleton Vertex
  - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator
  - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months
  - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months
  - Use of Opioids From Multiple Providers (4 or more prescribers)

- The following opportunities were noted in 2020 (MY 2019) for Adult and Child CAHPS survey items:
    - Of the four Adult CAHPS composite survey items reviewed, one item fell below the 2020 MMC weighted average. One item decreased between 2020 (MY 2019) and 2019 (MY 2018).
    - Of the four Child CAHPS composite survey items reviewed, one item fell below the 2020 MMC weighted average.

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

P4P Measure Matrix Report Card 2020

The Pay-for-Performance (P4P) Matrix Report Card provides a comparative look at all measures in the Quality Performance Measures component of the "HealthChoices MCO Pay for Performance Program." Ten measures are Healthcare Effectiveness Data Information Set (HEDIS®) measures, one is a PA specific measure, and one is 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 (2020 and 2019); and
2. Compares the MCO's 2020 P4P measure rates to the 2020 Medicaid Managed Care (MMC) Weighted Average.

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

The vertical comparison represents the MCO's performance for each measure in relation to its prior year's rates for the same measure. The MCO's rate can trend up (⇧), have no change, or trend down (⇩). For these year-to-year comparisons, the statistical significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

The matrix is color-coded to indicate when a MCO's performance rates for these P4P measures are notable or whether there is cause for action:

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

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

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

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

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

GEI Key Points

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

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

- Medication Management for People With Asthma: 75% Total
- Developmental Screening in the First Three Years of Life[1]

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

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

- Prenatal Care in the First Trimester
- Postpartum Care

Measure(s) that in 2020 did not statistically significantly change from 2019, but are statistically significantly above/better than the 2020 MMC weighted average:

- Comprehensive Diabetes Care: HbA1c Poor Control[2]

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

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

- Adolescent Well-Care Visits
- Controlling High Blood Pressure
- Well-Child Visits in the First 15 Months of Life, 6 or more
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Lead Screening in Children[3]

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

- Reducing Potentially Preventable Readmissions[4]

D - Root cause analysis and plan of action required.

No P4P measures fell into this comparison category.

F - Root cause analysis and plan of action required.

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

- Annual Dental Visit (Ages 2—20 years)

[1] Developmental Screening in the First Three Years of Life was added as a P4P measure in 2020 (MY 2019).
[2] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
[3] Lead Screening in Children was added as a P4P measure in 2020 (MY 2019).
[4] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance

Figure 5.1: P4P Measure Matrix

		Medicaid Managed Care Weighted Average Statistical Significance Comparison		
	Trend	**Below/Worse than Average**	**Average**	**Above/Better than Average**
Year to Year Statistical Significance Comparison	⬆	**C**	**B** Prenatal Care in the First Trimester Postpartum Care	**A** Medication Management for People With Asthma: 75% Total Developmental Screening in the First Years of Life[5]
	No Change	**D**	**C** Adolescent Well-Care Visits Controlling High Blood Pressure Well-Child Visits in the First 15 Months of Life, 6 or more Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Lead Screening in Children[6]	**B** Comprehensive Diabetes Care: HbA1c Poor Control[7]
	⬇	**F** Annual Dental Visit (Ages 2—20 years)	**D**	**C** Reducing Potentially Preventable Readmissions[8]

[5] Developmental Screening in the First Three Years of Life was added as a P4P measure in 2020 (MY 2019).
[6] Lead Screening in Children was added as a P4P measure in 2020 (MY 2019).
[7] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
[8] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance

P4P performance measure rates for 2017, 2018, 2019, and 2020 as applicable are displayed in Table 5.1. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

- ▲ 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®	HEDIS® 2017 Rate	HEDIS® 2018 Rate	HEDIS® 2019 Rate	HEDIS® 2020 Rate	HEDIS® 2020 MMC WA
Adolescent Well-Care Visits (Age 12-21 Years)	55.4% =	60.7% =	61.0% =	61.0% =	64.3%
Comprehensive Diabetes Care - HbA1c Poor Control[9]	34.5% ▲	32.3% =	29.1% =	29.1% =	33.7%
Controlling High Blood Pressure	72.0% =	70.5% =	71.8% =	71.8% =	68.3%
Prenatal Care in the First Trimester	90.5% =	86.6% =	85.2% =	91.7% ▲	91.7%
Postpartum Care	65.9% ▼	70.3% =	68.6% =	82.0% ▲	79.3%
Annual Dental Visits (Ages 2 – 20 years)	57.7% ▲	57.8% =	58.5% ▲	54.4% ▼	65.8%
Well-Child Visits in the First 15 Months of Life, 6 or more	72.0% =	74.9% =	74.1% =	74.1% =	73.5%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.7% =	79.9% =	77.1% =	78.7% =	79.6%
Medication Management for People with Asthma: 75% Total	47.5% ▲	47.9% =	51.2% ▲	53.9% ▲	45.3%
Lead Screening in Children[10]				82.2% =	83.6%
Quality Performance Measure – Other	**2017 Rate**	**2018 Rate**	**2019 Rate**	**2020 Rate**	**2020 MMC WA**
Reducing Potentially Preventable Readmissions[11] (PA-specific)	10.6% ▲	9.6% ▼	9.4% =	10.2% ▲	11.3%
Developmental Screening in the First Three Years of Life[12] (CMS Child Core)				65.4% ▲	61.0%

[9] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
[10] Lead Screening in Children was added as a P4P measure in 2020 (MY 2019).
[11] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance
[12] Developmental Screening in the First Three Years of Life was added as a P4P measure in 2020 (MY 2019).

VI: Summary of Activities

Performance Improvement Projects

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

Performance Measures

- GEI reported all HEDIS, PA-Specific, and CAHPS Survey performance measures in 2020 for which the MCO had a sufficient denominator.

Structure and Operations Standards

- GEI was found to be fully compliant on Subparts C, E, and F. Compliance review findings for GEI from RY 2020, RY 2019, and RY 2018 were used to make the determinations, which incorporates both the prior and the new set of EQR protocols.

2019 Opportunities for Improvement MCO Response

- GEI provided a response to the opportunities for improvement issued in the 2019 annual technical report and a root cause analysis and action plan for those measures on the HEDIS 2019 P4P Measure Matrix receiving either "D" or "F" ratings.

2020 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for GEI in 2020. A response will be required by the MCO for the noted opportunities for improvement in 2021.