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Keystone First
External Quality Review
Annual Technical Report

April 2024

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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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I. Executive Summary

Purpose of Report

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

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

To comply with *Title 42 CFR § 438.364 External review results (a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Commonwealth of Pennsylvania Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) contracted with IPRO, an EQRO, to conduct the 2023 EQR activities for MCOs contracted to furnish Medicaid physical health (PH) services in the state. HealthChoices Physical Health is the mandatory managed care program that provides Medical Assistance (MA) recipients with PH services in Pennsylvania. During the external quality review period, January 1, 2023, to December 31, 2023, Pennsylvania's HealthChoices Physical Health MCOs included Keystone First (FK). This report presents results of these EQR activities for FK.

Scope of External Quality Review Activities Conducted

This EQR ATR focuses on the four mandatory and one optional EQR activities that were conducted. These activities are:

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

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

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

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

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

(v) ***CMS Optional Protocol 6:*** **Validation of Quality-of-Care Surveys –** In 2023, satisfaction surveys were conducted for adult and child members. The member survey measured satisfaction with care received, providers, and health plan operations.

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

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

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

While the *CMS External Quality Review (EQR) Protocols* published in January 2023 stated that an Information Systems Capabilities Assessment (ISCA) is a required component of the mandatory EQR activities, CMS previously clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. Findings from IPRO's review of the MCO's HEDIS final audit report (FAR) are in **Section III: Validation of Performance Measures**.

Conclusions and Recommendations

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

Findings from MY 2022 EQR activities highlight KF's continued commitment to achieving the goals of the Pennsylvania Medicaid Quality Strategy. Strengths related to quality of care, timeliness of care, and access to care were observed in the implementation of performance improvement projects, performance measure rates, compliance with regulatory requirements, and quality of care survey scores; however, there were also important shortcomings in each that can be addressed through ongoing quality measurement, reporting, and improvement activities. **Table 38** provides specific information on KF's strengths, opportunities, and IPRO recommendations for improvement.

II. Validation of Performance Improvement Projects

Objectives

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

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

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, Pennsylvania contracted with IPRO to validate the PIPs that were underway in 2022.

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

These PIPs extended from January 2019 through December 2022. With research beginning in 2019, initial PIP proposals were developed and submitted in third quarter 2020, and the final report was 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 2023, final reports were due in October. These reports underwent initial review by IPRO, and feedback was provided to plans, with a timeline to resubmit to address areas of concern.

For each PIP, all physical health managed care organizations (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 regarding expectations for PIP relevance, quality, completeness, resubmissions, and timeliness.

As part of the new EQR PIP cycle that was initiated for all Medicaid MCOs in 2020, IPRO adopted the Lean methodology, following the CMS recommendation that quality improvement organizations (QIOs) and other healthcare stakeholders embrace Lean to promote continuous quality improvement (QI) 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 PIPs. These protocols follow a longitudinal format and capture information relating to:

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

OMAP selected the following topics as PIPs for all Medicaid PH-MCOs in the state: "Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits" and "Preventing Inappropriate Use or Overuse of Opioids." While the topics were common to PH-MCOs, projects were developed individually by each PH-MCO. PH-MCOs conducted independent analyses of their data to develop relevant performance measures and interventions. PH-MCOs were responsible for coordinating, implementing, and reporting their projects.

Performance Improvement Project Topics

"Preventing Inappropriate Use or Overuse of Opioids" was selected because on average, 187 Americans die every day from opioid overdose.[Error! Bookmark not defined.] In 2020, Pennsylvania had the ninth highest rates among states for death due to drug overdose, at 42.4 per 100,000.[4] Considering this, governmental regulatory agencies have released multiple measures and societal recommendations to decrease the number of opioid prescriptions. Pennsylvania DHS has sought to implement these measures as quickly as possible to impact its at-risk populations.

Because opioid misuse and abuse is a national crisis, and due to the impact this has had particularly on Pennsylvania, the PIP is centered on opioids in the following four common outcome objectives: opioid prevention, harm reduction, coordination/facilitation into treatment, and increase medication-assisted treatment (MAT) utilization.

"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits" was selected because avoidable emergency department (ED) utilization rates, preventable hospitalization, and rehospitalization within 30 days can be seen as indicators of the quality and efficiency of the healthcare system (ambulatory care and inpatient care) as well as patients' adoption of healthy lifestyle and active self-management of chronic conditions.[5]

Populations at greater risk of avoidable ED visits, hospitalization, and readmission include individuals living with challenges to the social determinants of health (SDoH)[6,7] and people diagnosed with serious persistent mental illness (SPMI).[8,9] In 2016, Pennsylvania implemented the PH-MCO and behavioral health managed care organization (BH-MCO) Integrated Care Plan (ICP) Program Pay for Performance Program to address the needs

[4] Centers for Disease Control and Prevention (CDC). *2020 drug overdose death rates | Drug overdose | CDC Injury Center*. 2020 Drug Overdose Death Rates | Drug Overdose | CDC Injury Center.

[5] Agency for Healthcare Research and Quality (AHRQ). *Preventable emergency department visits*. Preventable Emergency Department Visits | Agency for Healthcare Research and Quality (ahrq.gov)

[6] SDoH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

[7] CDC. (2022). *Social determinants of health at CDC*. Social Determinants of Health at CDC | About | CDC.

[8] Peters, Z. J., Santo, L., Davis, D., & DeFrances, C. J. (2023). Emergency Department Visits Related to Mental Health Disorders Among Adults, by Race and Hispanic Ethnicity: United States, 2018–2020. *National health statistics reports*, (181), 1–9. https://dx.doi.org/10.15620/cdc:123507.

[9] Penzenstadler, L., Gentil, L., Grenier, G., Khazaal, Y., & Fleury, M. J. (2020). Risk factors of hospitalization for any medical condition among patients with prior emergency department visits for mental health conditions. *BMC psychiatry*, *20*(1), 431. https://doi.org/10.1186/s12888-020-02835-2.

of individuals with SPMI through person-centered care planning, advance discharge planning, and medication management.

Because interventions by MCOs are needed to improve patient care and reduce hospital cost, the PIP had the following outcome objectives: leverage care coordination and integration of services to reduce the rate of ambulatory-sensitive ED visits, preventable hospitalizations, and 30-day readmissions, focusing on populations at greatest risk to address healthcare disparities.

Technical Methods of Data Collection and Analysis

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

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

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCO's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the MCO's enrollment and generalizable to the MCO's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the PIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the MCO achieved sustained improvement.

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

Scoring elements and methodology are used during the intervention and sustainability periods. MY 2019 was the baseline measurement period, and in 2020, proposal reports were due from MCOs. MYs 2020 and 2021 were interim measurement review years, with reports due in 2021 and 2022. Elements were reviewed and scored at multiple points during the year once interim reports were submitted. All MCOs received some level of guidance towards improving their projects in these findings, and MCOs responded accordingly with resubmissions to correct specific areas. MY 2022 was the final measurement period, and elements were reviewed and scored once final reports were submitted in October 2023. These review findings are included in each MCO's ATR.

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

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.

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

Table 1: Element Designation

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

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

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. As noted in **Table 2**, PIPs are also reviewed for the achievement of sustained improvement. Sustained improvement is assessed for the final year of a PIP, in this case, for MY 2023. The evaluation of the sustained improvement area has two review elements. These review elements have a total weight of 20%, for a possible maximum total of 20 points. To receive these points, the MCO must sustain improvement relative to baseline after achieving demonstrable improvement.

Table 2: Review Element Scoring Weights (Scoring Matrix)

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

IPRO provided PIP report templates to each MCO for the submission of project proposals, interim updates, and results. All data needed to conduct the validation were obtained through these report submissions.

Description of Data Obtained

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

For the **"Preventing Inappropriate Use or Overuse of Opioids"** PIP, 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 Pennsylvania Centers of Excellence (COE) for Opioid Use Disorder program and incentives under the DHS Quality Care Hospital Assessment Initiative.

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) – This HEDIS measure "assesses potentially high-risk opioid analgesic prescribing practices: 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."[10]
- Use of Opioids from Multiple Providers (UOP) – This HEDIS measure "assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥ 15 days during the measurement year 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)."[11]
- Risk of Continued Opioid Use (COU) – This HEDIS measure "assesses potentially high-risk opioid analgesic prescribing practices. The percentage of members 18 years 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."[12]
- Concurrent Use of Opioids and Benzodiazepines (COB-AD) – This CMS Adult Core Set measure "addresses two measurement areas: early opioid use and polypharmacy. This measure examines the percentage of beneficiaries with concurrent use of prescriptions for opioids and benzodiazepines, which is linked to an increased risk of morbidity and mortality."[13]
- Percent of Individuals with Opioid Use Disorder (OUD) Who Receive MAT (MCO-defined).
- Percentage of Adults > 18 Years with Pharmacotherapy for OUD Who Have (MCO-defined) at Least:
  - 90 Days; and

[10] NCQA. (2023). *Use of opioids at high dosage*. Use of Opioids at High Dosage - NCQA.
[11] NCQA. (2023). *Use of opioids from multiple providers*. Use of Opioids from Multiple Providers - NCQA.
[12] NCQA. (2023). *Risk of continued opioid use*. Risk of Continued Opioid Use - NCQA.
[13] CMS. (2020). *Overview of substance use disorder measures in the 2020 adult and health home core sets*. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2020.factsheet-sud-adult-core-set_0.pdf.

- 180 Days of Continuous Treatment.
- Follow-Up Treatment within 7 Days After ED Visit for OUD (MCO-defined).

For the **"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits"** PIP, DHS directed MCOs to define and collect ICP measures to address challenges with the previous PIP and give MCOs more control and increased ability to implement interventions that directly impact their populations. Rates for the ICP program are calculated by IPRO annually during the late fourth quarter, using encounters submitted by both the PH-MCOs and the BH-MCOs to PROMIS*e*™, Pennsylvania's claims processing, provider enrollment, and user management information system. 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 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 this PIP, OMAP has required all PH-MCOs to submit the following core measures on an annual basis:

- Ambulatory Care (AMB): ED Utilization – This HEDIS measure summarizes utilization of ambulatory care in EDs.[14]
- Inpatient Utilization – General Hospital/Acute Care (IPU): Total Discharges – This HEDIS measure "summarizes utilization of acute inpatient care and services in the following categories:
  - maternity,
  - surgery,
  - medicine, and
  - total inpatient (the sum of Maternity, Surgery and Medicine)."[14]
- Plan All-Cause Readmissions (PCR): This HEDIS measure "assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge" for Medicaid members ages 18 to 64 years.[15]
- 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 and ethnicity barriers and identify interventions that will be implemented to remediate the barriers identified.

Conclusions and Comparative Findings

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

[14] NCQA. (2021). *HEDIS MY 2022 measure descriptions*. HEDIS-MY-2022-Measure-Descriptions.pdf (ncqa.org).
[15] NCQA (2023). *Plan all-cause readmissions*. Plan All-Cause Readmissions - NCQA.

Throughout 2023, the final year of the cycle, there were several levels of communication provided to MCOs after their second interim submissions and in preparation for their final submissions, including:

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

In response to the feedback provided, MCOs were requested to revise and resubmit their documents to address the identified issues and to review again. PIP-specific calls were held with each MCO that experienced continued difficulty, attended by both DHS and IPRO. Additionally, as needed, Pennsylvania DHS discusses ongoing issues with MCOs as part of their regularly scheduled monitoring calls. As noted, for the current review year, 2023, MCOs were requested to submit a final report, including updated rates and interventions. Review teams consisted of one clinical staff member and one analytical staff member. Following initial review, MCOs were asked to update their submission according to the recommendations noted in the findings. **Table A1** of the MCO's interventions for the project can be found in **Appendix A**.

Preventing Inappropriate Use or Overuse of Opioids

KF's baseline proposal demonstrated that the topic reflects high-volume/high-risk conditions for the population under review. The MCO provided statistics that quantified membership with OUD and/or receiving MAT and further characterized opioid use by demographic attributes such as age, sex, race, ethnicity, residence, and special characteristics such as pregnancy.

KF provided detailed aims and objectives, in which they describe the interventions they plan to implement, the targeted populations of the interventions, and how the interventions will improve rates for the performance indicators. However, it is recommended that the MCO provide more detail for Indicator 7 (Follow-Up Treatment within 7 days After ED Visit for Opioid Use Disorder), for which the objective relies on home visitation for members with OUD who are pregnant. Because there is no intervention targeting members with OUD who visited the ED, the PIP would benefit from a description of how these two groups might overlap. This was not addressed in the MCO's October 2021 interim report.

For the "Preventing Inappropriate Use or Overuse of Opioids" PIP, 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. The information provided by KF for all measures demonstrates that they are clearly defined and measurable. The indicators measure changes in health status, functional status, and satisfaction or processes of care with strong associations with improved outcomes. KF plans to measure the indicators 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 MCO's barrier analysis used medical and pharmacy claims analysis, multi-disciplinary quality committee discussions, and feedback from network providers, BH-MCO partners, care management/care coordination/health equity teams, community navigators, and community-based organizations. Further, KF highlighted five interventions involving member outreach, provider education, and interventions in the community to address prolonged prescription opioid use, concurrent opioid and benzodiazepine use, continuation of MAT, and pregnancy. A particular strength was identified as the use of a pharmacy-led education team for more than one intervention. In its proposal resubmission, the plan addressed the recommendation to clarify and consistently state the target population for its Bright Start Home Visitation

intervention. The MCO also added an intervention that involves telephonic outreach to follow up with emergency room overdoses.

In October 2021, KF submitted an interim report for this project. The MCO's Project Topic section did not include updates that were recommended by reviewers for their proposal report. The MCO was encouraged to review statistics cited for African American pregnant women with addiction and compare to Pennsylvania Department of Health (DOH) data. The MCO's COB indicator was noted as one that should be divided into two age groups, ages 18−64 years and 65 years of age and older. Measures were defined and statements related to intended review of monthly performance are included. However, there was no indication that monthly or bimonthly review took place, based on lack of goal revision and interventions having a delayed start of January 2021. Likely due to this, no data for any intervention tracking measures (ITMs) were reported in KF's interim report.

One new intervention, Emergency Room Overdose Follow-Up, was added to the MCO's interim report. In this intervention, a Rapid Response Outreach Team will make telephonic calls to identified members who have been to the ED with a diagnosis of overdose to assist with coordination of care and referral to appropriate resources. This intervention was slated to begin in January 2022. A corresponding ITM was developed, tracking the percentage of members successfully contacted following an ED visit with a diagnosis of overdose. The MCO provided updated data in the Results section for all indicators for the Interim period. While more than half of the indicator rates exceeded baseline goals with no interventions in place, goals were not revised.

While KF included discussion points for specific indicators, the MCO was encouraged to treat this section as a response to PIP performance thus far and to limit reiterating results from data provided in other parts of the report. The Discussion section did not include a discussion of study limitations.

In October 2022, the MCO submitted a second interim report for this project. The issue regarding Indicator 7 remained unaddressed. The MCO included an intervention for home visits for pregnant African American women with OUD and an intervention for telephonic outreach for members seen in the ED with a diagnosis of overdose. However, it was noted that it remains unclear how these interventions overlap to meet the stated objective and was recommended that the MCO clarify this in their report.

Multiple target rates were updated in 2022 based on meeting or exceeding goals during the interim period. The plan was encouraged to update their Rationale section to explain the new targets and how they were set. The results presented indicated 5 of 11 indicators improved from prior MY. However, three of the six interventions began in December 2021 and two of the six interventions were delayed until 2022. Reviewers observed that interventions have not been in place long enough for meaningful analysis of ITMs, and it was noted to the plan during review that the indicator rate changes cannot be attributed to the interventions. Of the interventions that have been started, numerators and denominators are low, suggesting the data are not representative of the entire eligible population. In addition, the report submitted did not include evidence of completion of analysis to inform timely modifications of interventions. The MCO was asked to include detail regarding any analysis of delayed implementation and barriers. In terms of discussion of results, reviewers noted that the discussion continues to be a restatement of the results. The MCO was again encouraged in 2022 to develop the Discussion section further to incorporate interpretation of the role of interventions, ITMs, and barriers addressed.

In October 2023, the MCO submitted a final report for this project. Several key points were identified for consideration and improvement. Notably, the objective related to pregnant women with OUD was removed from Indicator 7. While all interventions were initiated, there were concerns regarding delayed interventions implemented in 2022. Although the plan outlined monitoring of ITMs on a bimonthly basis, there was a lack of

evidence indicating timely modifications of low-performing interventions. Recommendations included subsequent barrier analysis for interventions and ITMs during the next PIP cycle. Reviewers noted that specific details about Intervention 1, targeting members newly started on opioids by dental providers, required clarification and further discussion.

The PIP's Discussion section noted potential changes to interventions, including a value-based payment (VBP) model and educational mailers. However, delays in intervention implementation made it challenging to assess the impact on performance improvement. Recommendations highlighted the need for more detailed barrier analysis and early intervention modification in subsequent PIP cycles. Six of 11 indicators improved rates, with five ITMs implemented in the 2021 fourth quarter exhibiting low performance. The recommendation emphasized incorporating barrier analysis and updated interventions for continued interventions in the next PIP, ensuring a timely review of trends.

While the Next Steps section outlined objectives met and barriers mentioned, there was limited discussion on ITM rates and findings of barrier analysis leading to modifications of low-performing interventions. Recommendations included a more in-depth discussion on barrier analysis in relation to ITM rates, shifting these discussions to the Discussion section in the next PIP. Less than half of the indicators exhibited sustained improvement, prompting the need for a more comprehensive discussion on barrier analysis related to indicator rates for continuing interventions in the next PIP. The validation findings suggested that the credibility of the PIP results was generally not at risk but should be interpreted with caution due to difficulties in ascertaining the impact of interventions on overall indicator performance, primarily because of delayed implementation towards the end of the PIP cycle. Recommendations were provided to the plan in light of these findings, as noted below. **Table A1** of the MCO's interventions for the project can be found in **Appendix A**.

The following recommendations were identified during the final report review process:

- It was recommended to remove the pregnant women with OUD objective from Indicator 7.
- It was recommended to ensure timely modifications of low-performing interventions through subsequent barrier analysis and recommendations during subsequent measurement periods in the next PIP cycle.
- It was recommended to include further barrier analysis for low-performing interventions that will continue in the next PIP.
- It was recommended to provide more detail on Intervention 1, targeting members newly started on opioids by dental providers, including discussion regarding the specificity of fourth quarter data to this patient population.
- It was recommended to ensure quarterly data corresponding to implementation dates for all ITMs in the PIP.
- It was recommended to consider a more detailed barrier analysis and earlier modification of interventions if they are delayed.
- It was recommended to include barrier analysis and updated/modified interventions/ITMs for continued interventions in the next PIP, adhering to timely trend review as per the data analysis plan.
- It was recommended to move discussions related to ITM rates, findings of barrier analysis, and modifications of low-performing interventions from the Next Steps section to the Discussion section in the next PIP.
- It was recommended to provide a more in-depth discussion on barrier analysis in relation to indicator rates for interventions continuing in the next PIP.
- It was recommended to consider the limited time frame for assessing the impact of interventions that began in the second quarter or later of the MY.

- It was recommended to interpret the validation findings with caution, acknowledging that the credibility of PIP results is generally not at risk.
- It was recommended to address the challenge of ascertaining the impact of interventions on overall indicator performance due to delayed implementation mostly at the end of the PIP cycle.

Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits
KF'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. Further, the MCO provided statistics that assessed ED utilization and clinical data for racial and ethnic disparities, noting one focus of the PIP will be on African American members with diabetes and/or SPMI.

The aim and objectives statements that the MCO provided specified performance indicators for improvement with corresponding goals, and objectives that align the aim and goals with the interventions that were developed. However, it was noted during baseline review that KF should consider revisiting the target rate goals for Indicator 1, Ambulatory Care: Emergency Department Visits, and Indicator 2, Inpatient Utilization: Total Discharges. Each target rate goal leads to more than a 17% decrease from the respective baseline rate. It is recommended that the MCO develop goals that are bold, yet feasible.

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 indicators 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. The performance indicators are clearly defined and measurable, and they measure changes in health status, functional status, and satisfaction or processes of care with strong associations with improved outcomes. KF plans to measure the indicators 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 used claims analysis and multi-disciplinary quality committee meeting discussions, as well as feedback from network providers, BH-MCO partners, care management/care coordination/health equity teams, community navigators, and community-based organizations. Particular strengths of this PIP were identified as the multiple member outreach initiatives undertaken to support the populations identified earlier. The use of Transition of Care Pathway and Diabetes Pathway, as well as measurement of member completion, suggest an ongoing effort. The related ITMs assess the desired outcomes, such as appointment receipt, or reduction in ED visits or readmissions. Although one intervention promoted the MD Line and telehealth appointment use by members, it was noted that an opportunity to further strengthen the PIP would be to expand provider involvement.

In October 2021, KF submitted an interim report for this project. The MCO's Project Topic section did not include updates that were recommended by reviewers for their proposal report. Clarifying questions and guidance were provided to the MCO regarding several ITMs to bring aims, objectives, and interventions more into alignment. While it appeared that the MCO understands its processes and goals, KF was encouraged to clarify exactly what is being measured and what calculations are showing in their PIP to better demonstrate that knowledge.

The MCO provided updated data in the Results section for all but one of the indicators for the interim period. While two-thirds of the indicator rates exceeded baseline goals, they were not revised. Reaching or exceeding goals should always inform an increased goal or expanded use of successful interventions to support PIP goals.

In the PIP's Discussion section, comments made regarding the effects of the 2019 novel coronavirus (COVID-19) on results and difficulty with obtaining data were included in discussion. Conclusions drawn in interpreting data and results may be clearer if clarifications and consistency is improved, per recommendations provided to the MCO. Despite disparities and inconsistencies with aligned barriers, topic populations, indicators, and interventions, the results of the first Interim reporting period showed strong improvements across most performance indicators, and a considerable number of goals set at baseline were exceeded. It was noted that if goals continue to be met/exceeded in future reports, it may be helpful to consider expanding the most successful interventions in the final year or in the Next Steps section of the final report.

In October 2022, the MCO submitted a second interim report for this project. Target goals were adjusted towards smaller improvements for Indicators 1 and 2, with the MCO citing a couple of factors: anticipated increased ED and inpatient visits for other reasons due to the COVID-19 pandemic easing and the change in membership as result of reprocurement. Two interventions (2 and 4) were delayed until 2022, thus no data were provided for analysis at this point in the project. Intervention 2 is the only intervention addressing the identified high-risk population of infants < 1 year of age and their caregivers. Intervention 4 is the only intervention addressing barrier 3 (member ability to attend primary care provider [PCP] appointment following hospitalization). Results were provided where possible, and a Discussion section noted future changes to interventions. When comparing MY 2021 to MY 2020, there was improvement noted in three of the nine performance indicators. When comparing MY 2021 to baseline, there was improvement noted in six of the nine performance indicators. It was observed that the Discussion section indicated there were no threats to internal or external validity, and data collection challenges were detailed, including vendor contract delays, COVID-19, and limited data sharing between PH- and BH-MCOs. However, reviewers noted inconsistencies with the discussion, including data provided on the Rapid Response team although this intervention (2) was delayed until 2022. Reviewers asked if this information referred to the Care Connector call in Intervention 1 and requested that the plan clarify for consistency. Additionally, ED outreach is noted to connect members to any BH needs and any alcohol or drug treatments as needed. Reviewers stated that this is a loose connection to Indicator 4a and asked if there were data available supporting the number of members identified with these needs or related referral made. This would strengthen the support for Indicator 4a but does not support Indicator 4b.

In October 2023, the MCO submitted a final report for this project. Several outstanding issues from previous reviews persisted, necessitating attention and clarification. Specific details were needed regarding Indicator 4b, ITMs 5a and 5b, and Indicator 7, if these elements were to continue in future PIPs. Although a previous review's comment was addressed, it was recommended that the updated target goal rate information be included in the Target Rate Rationale section. The eligible population for Indicator 3 had yet to be revised, and the absence of barrier analysis and interventions for Indicator 4b required discussion.

Intervention 2 was implemented in the first quarter of 2022 , and Intervention 4 began in the second quarter of 2022. However, concerns arose with Intervention 4, as it had limited members in the numerator and denominator, making it challenging to assess the validity and reliability of the data representation for the entire eligible population. Issues with ITM 3a persisted without resolution, and while the ITM 3a denominator increased significantly, there was a lack of specific discussion regarding modifications to increase the likelihood of performance outcomes for ITM 4a. The absence of the bimonthly review process specified in the data analysis plan for MY 2022 raised concerns, urging discussions regarding Intervention 6 and ITM 4a.

Many of the reviewers' comments from previous reviews remained unaddressed, including delayed start information for Intervention 4 in the Limitations section. Additional discussion was needed for Intervention 5, as well as ITMs 3a and 5b, if these interventions and ITMs were to continue in the next PIP. Elements 6, 14,

and 17 required discussion if these ITMs/interventions persisted in the next PIP, and outstanding issues on Element 6 from prior reviews needed attention.

The Next Steps section mentioned future 2024 meetings for a new barrier analysis and intervention modifications, but specific details on this analysis and tracking were required if these interventions continued in the next PIP. Notably, all required columns were added with correct data results, and tables with these results were updated to be consistent across the report for Indicators 1 and 2 target rates. Improvement was noted in six of the nine performance indicators when comparing MY 2022 to MY 2021 and to baseline. Sustained improvement was evident in six of the nine performance indicators from baseline to the final measurement period.

However, certain aspects still required clarification, such as the unclear intent of ITM 5b and the absence of interventions or barriers specifically addressing Indicator 4b. Additionally, the alignment between Indicator 7's aim, objective, and intervention needed clarification. Lessons learned from intervention implementation were documented, but there were no noted follow-up activities. Overall, sustained improvement was observed in six of the nine performance indicators, and validation findings suggested that the credibility of the PIP results was not at risk but should be interpreted with caution.

Concerns remained regarding unclear ITMs, making the assessment of performance improvement challenging. It was recommended to address these issues from previous reviews for interventions and ITMs that would continue in the next PIP.

Recommendations were provided to the plan in light of these interim findings, as noted below. **Table A1** of the MCO's interventions for the project can be found in **Appendix A**.

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

- It was recommended to include details regarding Indicator 4B, ITMs 5a and 5b, and Indicator 7.
- It was recommended to include updated target goal rate information in the target rate Rationale section with future PIP submissions.
- It was recommended to discuss Indicator 3 and 4b revisions, including barrier analysis and interventions, in the next PIP.
- It was recommended to evaluate the validity and reliability of Intervention 4 data, which had no members in the numerator and only one in the denominator in the fourth quarter of 2022.
- It was recommended to address outstanding issues related to Element 6 and ITM 3a and provide discussions on ITM 4a and Element 6 if they continue in the next PIP.
- It was recommended to discuss Intervention 5, ITMs 3a and 5b, and Elements 6, 14, and 17, if these interventions/ITMs continue in the next PIP.
- It was recommended to provide specific details on future 2024 meetings for a new barrier analysis and modifications to interventions, especially if these interventions continue in the next PIP.
- It was recommended to confirm that all required columns have been added with data results calculated correctly.
- It was recommended to ensure that information regarding Indicators 1 and 2 target rates were updated to be consistent across the MCO's report.
- It was recommended to discuss improvements noted in six of the nine performance indicators when comparing MY 2022 to MY 2021 and to baseline. Ensure discussion on these improvements for the corresponding ITMs.

- It was recommended to clarify the number of members identified as having BH/alcohol and other drug treatment needs during ED outreach calls, especially for Indicator 4a. Discuss previous reviewer's comments related to Indicator 4a if this intervention continues in the next PIP.
- It was recommended to document lessons learned from intervention implementation but provide follow-up activities and specifics on the new barrier analysis and planning session for modifications in 2024.
- It was recommended to highlight sustained improvement in six of nine performance indicators from baseline to the final measurement period.
- It was recommended to clarify the intent of ITM 5b, address issues related to Indicator 4b, and improve alignment between Indicator 7's aim, objective, and intervention.
- It was recommended to acknowledge validation findings that indicate the credibility of PIP results is not at risk but should be interpreted with caution.
- It was recommended to address unclear ITMs that impact the validity of performance improvement in relation to implemented interventions, especially for those interventions/ITMs continuing in the next PIP.

KF's final report compliance assessment by review element is presented in **Table 3**.

Table 3: KF PIP Compliance Assessments

Review Element	Preventing Inappropriate Use or Overuse of Opioids	Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits
1. Project Topic	Met	Partially Met
2. Methodology	Partially Met	Partially Met
3. Barrier Analysis, Interventions, and Monitoring	Partially Met	Partially Met
4. Results	Partially Met	Met
5. Discussion	Met	Partially Met
6. Next Steps	Met	Met
7. Validity and Reliability of PIP Results	Partially Met	Partially Met

PIP: performance improvement project; ED: emergency department.

III. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

The MCOs were provided with final specifications for the CMS Core Set and PAPMs from December 2022 to May 2023. Source code, raw data, and rate sheets were submitted by the MCOs to IPRO for review in 2023. A staggered submission was implemented for the performance measures. IPRO conducted an initial validation of each measure including source code review and provided each MCO with formal written feedback. The MCOs were then given the opportunity for resubmission, if necessary, with a limit of four total submissions. Additional resubmissions required discussion with and approval from DHS. Pseudo code was reviewed by IPRO. Raw data were also reviewed for reasonability, and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally, MCOs were provided with comparisons to the previous year's rates and were requested to provide explanations for highlighted differences. For measures reported as percentages, differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates. For measures not reported as percentages (e.g., adult admission measures), differences were highlighted based only on statistical significance, with no minimum threshold.

HEDIS MY 2022 Health Plan measures were validated through a standard HEDIS compliance audit of each PH-MCO. The audit protocol includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of the Interactive Data Submission System (IDSS). For HEDIS MY 2022, audit activities continued to be performed virtually due to the COVID-19 public health emergency. A FAR was submitted to NCQA for each MCO.

Description of Data Obtained

Evaluation of MCO performance is based on PAPMs, CMS Core Set measures, and HEDIS Health Plan measures for the EQR. It is DHS's practice to report all first-year performance measures for informational purposes. Relevant context regarding reported rates or calculated averages is provided as applicable, including any observed issues regarding implementation, reliability, or variability among MCOs. Additional discussion regarding MCO rates that differ notably from other MCOs will be included in the MCO-specific findings as applicable.

Pennsylvania Performance Measures

MCOs collect PAPMs, "which are a set of state quality measures that were developed focusing on specific areas of importance to the commonwealth that are not captured through other available data sets. PAPMs use statistically valid methodologies and allow program offices to track program performance over time. MCOs are required to report specific data for measures according to the requirements of the managed care program(s) in which they participate, and the most current year's measures selected. Data sources include,

but are not limited to, encounter data, participant interviews, patient experience surveys, on-site documents, electronic file reviews, quarterly, and annual reports."[16]

CMS Core Set Measures

The CMS measures are known as Core Set measures and are indicated below for children and adults. For each indicator, the eligible population is identified by product line, age, enrollment, anchor date, and event/diagnosis. Administrative numerator positives are identified by date of service, diagnosis/procedure code criteria, and other specifications as needed. For MY 2022, these performance measure rates were calculated through one of two methods: 1) administrative, which uses only the MCO's data systems to identify numerator positives; and 2) hybrid, which uses a combination of administrative data and medical record review (MRR) to identify numerator "hits" for rate calculation.

A number of performance measures require the inclusion of PH and BH services. Due to the separation of PH and BH services for Medicaid, DHS requested that IPRO use encounters submitted by all PH- and BH-MCOs to DHS via the PROMIS*e* 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 PROMIS*e* encounter data, while for other measures, IPRO calculated the measures using PROMIS*e* encounter data for both the BH and PH data required.

HEDIS Health Plan Measures

Each MCO underwent a full HEDIS compliance audit in 2023. Development of HEDIS Health Plan measures and the clinical rationale for their inclusion in the HEDIS Health Plan measurement set can be found in the HEDIS MY 2022, Volume 2 narrative. 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 measures requiring a BH benefit (BH being carved out in PA), the long-term care and survey 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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Child Survey.

MY 2022 was the first year MCOs reported HEDIS Health Plan measures from the electronic clinical data systems (ECDS) domain. ECDS capture care that aligns with evidence-based practices and promote health information portability, leading to improvements in healthcare quality and timeliness. ECDS measures are calculated using electronic clinical data, as stated in their respective definitions.

NCQA added race and ethnicity stratification reporting guidelines for MY 2022 for the following measures:

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients With Diabetes
- Prenatal and Postpartum Care
- Child and Adolescent Well-Care Visits

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. The race reporting categories are White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian and other Pacific Islander, some other race, two or more races, asked but no answer, and unknown. The ethnicity

[16] PA DHS. (2020). *Medical Assistance and Children's Health Insurance Program managed care quality strategy*. 16-17. 2020 Medical Assistance Quality Assistance Strategy for Pennsylvania (pa.gov).

categories are Hispanic/Latino, not Hispanic/Latino, asked but no answer, unknown, and total (total of all categories). Comprehensive race and ethnicity data for this MCO can be found in **Table B1** in **Appendix B**.

Conclusions and Comparative Findings

The MCO successfully implemented all of the PAPM and Core Set measures for 2022 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. Additionally, the MCO successfully completed the HEDIS audit. The MCO received an Audit Designation of Report for all applicable measures.

Measure descriptions and MCO results are presented in **Tables 4–26** and in **Table B1** in **Appendix B** for the race and ethnicity tables. For each measure, the denominator, numerator, and MY rates with 95% upper and lower confidence intervals (95% CI) are presented. Confidence intervals are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% CI indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would fall within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the CI 95 times, or 95% of the time.

Rates for both the MY and the previous year are presented, as available (i.e., MY 2022 and MY 2021). In addition, statistical comparisons are made between the MY 2022 and MY 2021 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the *Z* ratio. A *Z* ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."

In addition to each individual MCO's rate, the Medicaid managed care (MMC) average for MY 2022 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 the difference between the plan's MY rate and the MMC average for the same year. For comparison of MY 2022 rates to MMC rates, "+" denotes that the plan rate exceeds the MMC rate, "–" denotes that the plan rate is less than the MMC average, and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS Health Plan measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS Health Plan 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, strengths and opportunities corresponding to each table highlight only differences that are both statistically significant and display at least a 3-percentage-point difference in observed rates.[17] It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates might not yield statistical significance due to reduced power; if statistical significance is not achieved, results are not highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, "N/A" (not applicable) appears in the corresponding cells. However, "NA" (not available) also appears in the cells under the HEDIS MY 2022 percentile column for measures that do not have HEDIS percentiles to compare.

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

The measure data tables 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.

Access to/Availability of Care

The measures in the Access to/Availability of Care category are listed in **Table 4**, followed by the measure data in **Table 5**.

Table 4: Access to/Availability of Care Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
PA DHS	Adult Annual Dental Visit	-	Measure is calculated by IPRO	This measure assesses the percentage of adults 21 years of age and older who were continuously enrolled in the MCO for the MY and who had at least one dental visit during the MY.	Rate 1: Members ages 21 years and older. Rate 2: Women ages 21 years and older with a live birth.	Rate 1: Ages 21–35 years, ages 35–59 years, ages 60–64 years, 65 years of age and older, and total ages Rate 2: Ages 21–35 years, ages 36–59 years, and ages 21–59 years
NCQA	Adults' Access to Preventive/Ambulatory Health Services	-	Reported as a HEDIS audited measure	This measure assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during MY 2022.	N/A	Ages 20–44 years, ages 45–64 years, and 65 years of age and older
NCQA	Annual Dental Visit	-	Reported as a HEDIS-audited measure	This measure assesses the percentage of children and adolescents ages 2 to 20 years who were continuously enrolled in the MCO for the MY and who had at least one dental visit during the MY.	N/A	Ages 2–3 years, ages 4–6 years, ages 7–10 years, ages 11–14 years, ages 15–18 years, ages 19–20 years, and total ages
PA DHS	Annual Dental Visits for Members with Developmental Disabilities	-	Measure is calculated by IPRO	This measure assesses the percentage of Members with a developmental disability ages 2 to 20 years who were continuously enrolled and had at least one dental visit during the MY.	N/A	Ages 2–20 years
NCQA	Initiation and Engagement of Substance Use Disorder Treatment	✓	Measure is calculated by IPRO	This measure assesses the percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.	Rate 1: Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. Rate 2: Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. For each rate, the following SUD cohorts are reported: 1) alcohol use disorder; 2) opioid use disorder; 3) other SUD; and 4) the total sum of the SUD diagnosis cohort stratifications.	Ages 13–17 years, 18–64 years, 65 years of age and older, and 13 years of age and older
NCQA	Prenatal and Postpartum Care	✓	Reported as a HEDIS-audited measure	This measure assesses the percentage of deliveries of live births on or between October 8 of the year prior to the MY and October 7 of the MY.	Rate 1: 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. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	All member ages
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓	Measure is calculated by IPRO	This measure assesses the percentage of children and adolescents ages 1 to 17 years who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	N/A	Ages 1–11 years, ages 12–17 years, and total ages 1–17 years

NCQA: National Committee for Quality Assurance; PA DHS: Pennsylvania Department of Human Services; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; MCO: managed care organization; BH: behavioral health; PH: physical health; N/A: not applicable.

Strengths are identified for MY 2022 Access to/Availability of Care performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Annual Dental Visit (Ages 2 to 3 years) - 4.3 percentage points
  - Annual Dental Visit (Ages 4 to 6 Years) - 3.6 percentage points
  - Annual Dental Visit (Ages 7 to 10 years) - 3.0 percentage points
  - Annual Dental Visit (Ages 11 to 14 years) - 4.3 percentage points
  - Annual Dental Visit (Ages 15 to 18 years) - 4.6 percentage points
  - Annual Dental Visit (Ages 19 to 20 years) - 3.6 percentage points
  - Annual Dental Visit (Total) - 3.9 percentage points
  - Annual Dental Visits for Members with Developmental Disabilities - 4.4 percentage points

Opportunities for improvement are identified for MY 2022 Access to/Availability of Care performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 65 years and older) - 4.6 percentage points
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 20 to 44 years) - 5.0 percentage points
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 45 to 64 years) - 3.5 percentage points
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 65 years and older) - 14.1 percentage points
  - Adults' Access to Preventive/Ambulatory Health Services (Total) - 4.9 percentage points
  - Initiation and Engagement of Substance Use Disorder – Engagement of Substance Use Disorder – Alcohol Use Disorder (Ages 18 to 64 years) – 3.4 percentage points
  - Initiation and Engagement of Substance Use Disorder – Engagement of Substance Use Disorder – Alcohol Use Disorder (Total) – 3.4 percentage points
  - Initiation and Engagement of Substance Use Disorder – Engagement of Substance Use Disorder – Total (Ages 13 to 17 years) – 4.7 percentage points
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total) - 5.4 percentage points

Table 5: Access to/Availability of Care Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 21 to 35 years)	91,032	28,460	31.3%	31.0%	31.6%	32.7%	–	28.8%	+	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 36 to 59 years)	92,948	26,784	28.8%	28.5%	29.1%	29.7%	–	27.0%	+	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 60 to 64 years)	14,324	3,731	26.0%	25.3%	26.8%	26.2%	n.s.	24.4%	+	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 65 years and older)	3,426	628	18.3%	17.0%	19.6%	19.5%	n.s.	22.9%	–	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 21 years and older)	201,730	59,603	29.5%	29.3%	29.7%	30.6%	–	27.5%	+	NA
Adult Annual Dental Visit: Women with a Live Birth (Ages 21 to 35 years)	5,203	1,676	32.2%	30.9%	33.5%	35.3%	–	32.4%	n.s.	NA
Adult Annual Dental Visit: Women with a Live Birth (Ages 21 to 59 years)	6,116	1,950	31.9%	30.7%	33.1%	35.0%	–	32.3%	n.s.	NA
Adult Annual Dental Visit: Women with a Live Birth (Ages 36 to 59 years)	913	274	30.0%	27.0%	33.0%	33.5%	n.s.	31.6%	n.s.	NA
Adults' Access to Preventive/Ambulatory Health Services (Ages 20 to 44 years)	143,387	99,393	69.3%	69.1%	69.6%	72.3%	–	74.3%	–	≥ 25th and < 50th percentile
Adults' Access to Preventive/Ambulatory Health Services (Ages 45 to 64 years)	63,485	50,599	79.7%	79.4%	80.0%	81.0%	–	83.2%	–	≥ 25th and < 50th percentile
Adults' Access to Preventive/Ambulatory Health Services (Ages 65 years and older)	3,426	2,507	73.2%	71.7%	74.7%	75.5%	–	87.2%	–	≥ 25th and < 50th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Adults' Access to Preventive/Ambulatory Health Services (Total)	210,298	152,499	72.5%	72.3%	72.7%	75.0%	–	77.4%	–	≥ 25th and < 50th percentile
Annual Dental Visit (Ages 11 to 14 years)	43,443	31,411	72.3%	71.9%	72.7%	72.9%	–	68.0%	+	≥ 90th percentile
Annual Dental Visit (Ages 15 to 18 years)	40,763	25,746	63.2%	62.7%	63.6%	65.0%	–	58.6%	+	≥ 90th percentile
Annual Dental Visit (Ages 19 to 20 years)	17,144	7,261	42.4%	41.6%	43.1%	47.7%	–	38.8%	+	≥ 90th percentile
Annual Dental Visit (Ages 2 to 3 years)	22,346	12,809	57.3%	56.7%	58.0%	62.1%	–	53.1%	+	≥ 90th percentile
Annual Dental Visit (Ages 4 to 6 years)	33,544	24,781	73.9%	73.4%	74.4%	74.9%	–	70.3%	+	≥ 90th percentile
Annual Dental Visit (Ages 7 to 10 years)	43,215	32,630	75.5%	75.1%	75.9%	75.2%	n.s.	72.5%	+	≥ 90th percentile
Annual Dental Visit (Total)	200,455	134,638	67.2%	67.0%	67.4%	68.9%	–	63.2%	+	≥ 90th percentile
Annual Dental Visits for Members with Developmental Disabilities	13,665	9,440	69.1%	68.3%	69.9%	68.5%	n.s.	64.7%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 13 to 17 years)[3]	44	16	36.4%	21.0%	51.7%	N/A	N/A	36.1%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 18 to 64 years)[3]	3,658	1,499	41.0%	39.4%	42.6%	N/A	N/A	41.3%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 65 years and older)[3]	43	20	46.5%	30.4%	62.6%	N/A	N/A	45.2%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Total)[3]	3,745	1,535	41.0%	39.4%	42.6%	N/A	N/A	41.3%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 13 to 17 years)[3]	4	2	N/A	N/A	N/A	N/A	N/A	56.9%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 18 to 64 years)[3]	3,983	1,882	47.3%	45.7%	48.8%	N/A	N/A	45.8%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 65 years and older)[3]	19	8	N/A	N/A	N/A	N/A	N/A	42.5%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Total)[3]	4,006	1,892	47.2%	45.7%	48.8%	N/A	N/A	45.9%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 13 to 17 years)[3]	340	152	44.7%	39.3%	50.1%	N/A	N/A	42.3%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 18 to 64 years)[3]	5,442	2,548	46.8%	45.5%	48.2%	N/A	N/A	44.5%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 65 years and older)[3]	31	14	45.2%	26.0%	64.3%	N/A	N/A	41.1%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Total)[3]	5,813	2,714	46.7%	45.4%	48.0%	N/A	N/A	44.3%	+	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Ages 13 to 17 years)[3]	373	159	42.6%	37.5%	47.8%	N/A	N/A	41.2%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Ages 18 to 64 years)[3]	11,691	5,058	43.3%	42.4%	44.2%	N/A	N/A	42.2%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Ages 65 years and older)[3]	87	38	43.7%	32.7%	54.7%	N/A	N/A	42.3%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Total)[3]	12,151	5,255	43.2%	42.4%	44.1%	N/A	N/A	42.2%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 13 to 17 years)[3]	44	7	15.9%	4.0%	27.9%	N/A	N/A	21.8%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 18 to 64 years)[3]	3,658	587	16.0%	14.8%	17.3%	N/A	N/A	19.5%	-	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 65 years and older)[3]	43	8	18.6%	5.8%	31.4%	N/A	N/A	12.9%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Total)[3]	3,745	602	16.1%	14.9%	17.3%	N/A	N/A	19.5%	-	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 13 to 17 years)[3]	4	1	N/A	N/A	N/A	N/A	N/A	39.2%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 18 to 64 years)[3]	3,983	1,138	28.6%	27.2%	30.0%	N/A	N/A	30.8%	-	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 65 years and older)[3]	19	2	N/A	N/A	N/A	N/A	N/A	23.8%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Total)[3]	4,006	1,141	28.5%	27.1%	29.9%	N/A	N/A	30.8%	-	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 13 to 17 years)[3]	340	62	18.2%	14.0%	22.5%	N/A	N/A	22.7%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 18 to 64 years)[3]	5,442	1,115	20.5%	19.4%	21.6%	N/A	N/A	21.9%	-	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 65 years and older)[3]	31	5	16.1%	1.6%	30.7%	N/A	N/A	10.7%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Total)[3]	5,813	1,182	20.3%	19.3%	21.4%	N/A	N/A	21.9%	-	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Ages 13 to 17 years)[3]	373	65	17.4%	13.4%	21.4%	N/A	N/A	22.1%	-	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Ages 18 to 64 years)[3]	11,691	2,393	20.5%	19.7%	21.2%	N/A	N/A	22.6%	-	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Ages 65 years and older)[3]	87	14	16.1%	7.8%	24.4%	N/A	N/A	14.4%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Total)[3]	12,151	2,472	20.3%	19.6%	21.1%	N/A	N/A	22.5%	-	NA
Prenatal and Postpartum Care - Postpartum Care	411	335	81.5%	77.6%	85.4%	79.8%	n.s.	81.6%	n.s.	≥ 50th and < 75th percentile
Prenatal and Postpartum Care - Timeliness of Prenatal Care	411	358	87.1%	83.7%	90.5%	87.8%	n.s.	88.7%	n.s.	≥ 50th and < 75th percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11 years)	111	61	55.0%	45.2%	64.7%	60.0%	n.s.	61.9%	n.s.	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17 years)	402	231	57.5%	52.5%	62.4%	56.7%	n.s.	62.5%	n.s.	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	513	292	56.9%	52.5%	61.3%	57.5%	n.s.	62.3%	–	NA

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

[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

[3]The specification underwent severe changes in MY 2022. A year-to-year comparison is not applicable during this transition period.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Behavioral Health

The measures in the BH category are listed in **Table 6**, followed by the measure data in **Table 7**.

Table 6: Behavioral Health Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓	Reported as a HEDIS-audited measure and BH-enhanced[1]	This measure assesses the percentage of members 18 years of age and older during the MY with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	N/A	Members 18 years of age and older
NCQA	Antidepressant Medication Management	✓	Reported as a HEDIS-audited measure	This measure assesses the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.	Rate 1: Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). Rate 2: Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	18 years of age and older
NCQA	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	-	Reported as a HEDIS-audited measure	This measure assesses the percentage of members ages 18–64 years with schizophrenia or schizoaffective disorder and cardiovascular disease who had a low-density lipoprotein cholesterol (LDL-C) test during the MY.	N/A	Ages 18–64 years

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1C) Poor Control (> 9.0%)	✓	Measure is calculated by IPRO	This measure assesses the percentage of beneficiaries ages 18–75 years with a serious mental illness (SMI) and diabetes (type 1 and type 2) whose most recent HbA1c level during the MY was > 9.0%. A lower rate indicates better performance for this measure. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.	N/A	Ages 18–64 years and ages 65–75 years
NCQA	Diabetes Monitoring for People With Diabetes and Schizophrenia	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–64 years with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the MY. MY 2022 is the first report for this measure.	N/A	Ages 18–64 years
NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–64 years with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the MY. MY 2022 is the first report for this measure.	N/A	Ages 18–64 years
NCQA	Diagnosed Mental Health Disorders	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year. The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.	N/A	Ages 1–17 years, ages 18–64 years, 65 years of age and older, and total ages
NCQA	Diagnosed Substance Use Disorders	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members 13 years of age and older diagnosed with a substance use disorder (SUD) during the MY. The measure provides information on the diagnosed prevalence of SUDs. Neither a higher nor lower rate indicates better performance.	Rate 1: The percentage of members diagnosed with an alcohol disorder. Rate 2: The percentage of members diagnosed with an opioid disorder. Rate 3: The percentage of members diagnosed with a disorder for other or unspecified drugs. Rate 4: The percentage of members diagnosed with any SUD.	Ages 13–17 years, ages 18–64 years, 65 years of age and older, and total ages
NCQA	Follow-Up After Emergency Department Visit for Mental Illness	✓	Measure is calculated by IPRO	This measure assesses the percentage of emergency department (ED) visits for members 6 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.	Rate 1: 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). Rate 2: 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).	Ages 6–17 years, 18–64 years, and 65 years of age and older
NCQA	Follow-Up After Emergency Department Visit for Substance Use	✓	Measure is calculated by IPRO	This measure assesses the percentage of ED visits for members 13 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.	Rate 1: 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). Rate 2: 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).	Ages 13–17 years, 18–64 years, and 65 years of age and older
NCQA	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	✓	Reported as a HEDIS-audited measure and BH-enhanced[1]	This measure assesses the percentage of children newly prescribed 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.	Rate 1: Initiation Phase. The percentage of members ages 6–12 years as of the index prescription start date with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. Rate 2: Continuation and Maintenance Phase. The percentage of members 6–12 years of age as of the index prescription start date (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.	Ages 6–12 years

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of children and adolescents ages 1–17 years who had two or more antipsychotic prescriptions and had metabolic testing.	Rate 1: The percentage of children and adolescents on antipsychotics who received blood glucose testing. Rate 2: The percentage of children and adolescents on antipsychotics who received cholesterol testing. Rate 3: The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	Ages 1–11 years, ages 12–17 years, and total ages
NCQA	Pharmacotherapy for Opioid Use Disorder	-	Reported as HEDIS-audited measure	This measure assesses the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members ages 16 years and older with a diagnosis of OUD.	N/A	Ages 16–64 years, 65 years of age and older, and total ages
CMS	Screening for Depression and Follow-Up Plan	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter. MY 2022 is the first report for this measure	N/A	Ages 18–64 years, 65 years of age and older, and total ages
CMS	Use of Pharmacotherapy for Opioid Use Disorder	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of members with an OUD who filled a prescription for or were administered or dispensed a Food and Drug Administration (FDA)-approved medication for the disorder during the MY.	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.	Ages 18–64 years, 65 years of age and older, and total ages

[1] BH-enhanced: Measures based on physical health MCO HEDIS submissions and enhanced with data from BH-MCOs. To validate the measure, MCOs submit member level data files that match the MCO's HEDIS IDSS, IPRO validates the data files to ensure the appropriate information is received, and IPRO enhances the denominator and numerator values based on BH PROMIS*e* encounters.
NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; MCO: managed care organization; BH: behavioral health; PH: physical health; N/A: not applicable; IDSS: Interactive Data Submission System.

Strengths are identified for MY 2022 BH performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c) Poor Control (> 9.0%) (Ages 18 to 64 years) - 12.2 percentage points

Opportunities for improvement are identified for MY 2022 BH performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Adherence to Antipsychotic Medications for Individuals With Schizophrenia - 5.3 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 6 to 17 years) - 9.9 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 18 to 64 years) - 6.2 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 6 to 17 years) - 10.0 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 18 to 64 years) - 9.0 percentage points
  - Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase - BH Enhanced – 11.7 percentage points
  - Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - BH Enhanced – 8.5 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years) - 7.8 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years) - 4.4 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) - 5.1 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years) - 4.8 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) - 5.1 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years) - 7.8 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years) - 5.6 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) - 6.3 percentage points
  - Screening for Depression and Follow-Up Plan (Ages 18 to 64 years) - 4.2 percentage points
  - Screening for Depression and Follow-Up Plan (Ages 65 years and older) - 6.5 percentage points

- Screening for Depression and Follow-Up Plan (Total) - 4.3 percentage points
- Use of Pharmacotherapy for Opioid Use Disorder: Any Medication - 6.4 percentage points

Table 7: Behavioral Health Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	1,353	841	62.2%	59.6%	64.8%	62.8%	n.s.	67.5%	–	≥ 50th and < 75th percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia - BH Enhanced	2,782	1,940	69.7%	68.0%	71.5%	66.0%	+	71.8%	-	NA
Antidepressant Medication Management - Effective Acute Phase Treatment	5,768	3,465	60.1%	58.8%	61.3%	60.9%	n.s.	62.2%	–	≥ 25th and < 50th percentile
Antidepressant Medication Management - Effective Continuation Phase Treatment	5,768	2,523	43.7%	42.5%	45.0%	44.3%	n.s.	44.5%	n.s.	≥ 50th and < 75th percentile
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	43	39	90.7%	80.9%	100.5%	68.6%	+	81.6%	n.s.	≥ 90th percentile
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c) Poor Control (> 9.0%) (Ages 18 to 64 years)	1,095	1,026	93.7%	92.2%	95.2%	93.0%	n.s.	81.5%	+	NA
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c) Poor Control (> 9.0%) (Ages 65 to 75 years)	8	8	N/A	N/A	N/A	N/A	N/A	86.0%	N/A	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia	408	303	74.3%	69.9%	78.6%	72.8%	n.s.	76.0%	n.s.	≥ 75th and < 90th percentile
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	2,625	2,222	84.7%	83.3%	86.0%	86.6%	–	86.0%	n.s.	≥ 75th and < 90th percentile
Diagnosed Mental Health Disorders (Ages 1 to 17 years)	184,716	41,882	22.7%	22.5%	22.9%	N/A	N/A	26.1%	N/A	>= 75th and < 90th percentile
Diagnosed Mental Health Disorders (Ages 18 to 64 years)	226,334	61,366	27.1%	26.9%	27.3%	N/A	N/A	34.9%	N/A	>= 75th and < 90th percentile
Diagnosed Mental Health Disorders (Ages 65 years and older)	3,634	526	14.5%	13.3%	15.6%	N/A	N/A	39.2%	N/A	>= 10th and < 25th percentile
Diagnosed Mental Health Disorders (Total)	414,684	103,774	25.0%	24.9%	25.2%	N/A	N/A	31.4%	N/A	>= 75th and < 90th percentile
Diagnosed Substance Use Disorders - Alcohol (Ages 13 to 17 years)	53,655	26	0.1%	0.0%	0.1%	N/A	N/A	0.1%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Alcohol (Ages 18 to 64 years)	226,324	4,682	2.1%	2.0%	2.1%	N/A	N/A	2.5%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Alcohol (Ages 65 years and older)	3,632	32	0.9%	0.6%	1.2%	N/A	N/A	2.1%	N/A	< 10th percentile
Diagnosed Substance Use Disorders - Alcohol (Total)	283,611	4,740	1.7%	1.6%	1.7%	N/A	N/A	2.1%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Any (Ages 13 to 17 years)	53,655	194	0.4%	0.3%	0.4%	N/A	N/A	0.6%	N/A	>= 10th and < 25th percentile
Diagnosed Substance Use Disorders - Any (Ages 18 to 64 years)	226,324	15,583	6.9%	6.8%	7.0%	N/A	N/A	7.8%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Any (Ages 65 years and older)	3,632	69	1.9%	1.4%	2.4%	N/A	N/A	4.9%	N/A	< 10th percentile
Diagnosed Substance Use Disorders - Any (Total)	283,611	15,846	5.6%	5.5%	5.7%	N/A	N/A	6.5%	N/A	>= 50th and < 75th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Diagnosed Substance Use Disorders - Opioid (Ages 13 to 17 years)	53,655	4	0.0%	0.0%	0.0%	N/A	N/A	0.0%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Opioid (Ages 18 to 64 years)	226,324	8,204	3.6%	3.5%	3.7%	N/A	N/A	4.2%	N/A	>= 75th and < 90th percentile
Diagnosed Substance Use Disorders - Opioid (Ages 65 years and older)	3,632	25	0.7%	0.4%	1.0%	N/A	N/A	2.4%	N/A	>= 10th and < 25th percentile
Diagnosed Substance Use Disorders - Opioid (Total)	283,611	8,233	2.9%	2.8%	3.0%	N/A	N/A	3.5%	N/A	>= 75th and < 90th percentile
Diagnosed Substance Use Disorders - Other (Ages 13 to 17 years)	53,655	168	0.3%	0.3%	0.4%	N/A	N/A	0.5%	N/A	>= 10th and < 25th percentile
Diagnosed Substance Use Disorders - Other (Ages 18 to 64 years)	226,324	7,465	3.3%	3.2%	3.4%	N/A	N/A	3.3%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Other (Ages 65 years and older)	3,632	28	0.8%	0.5%	1.1%	N/A	N/A	1.1%	N/A	NA
Diagnosed Substance Use Disorders - Other (Total)	283,611	7,661	2.7%	2.6%	2.8%	N/A	N/A	2.8%	N/A	>= 25th and < 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 6 to 17 years)[3]	663	290	43.7%	39.9%	47.6%	N/A	N/A	53.7%	–	NA
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 18 to 64 years)	1,245	379	30.4%	27.8%	33.0%	36.9%	–	36.7%	–	NA
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 65 years and older)	3	1	N/A	N/A	N/A	N/A	N/A	26.7%	N/A	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 6 to 17 years)[3]	663	405	61.1%	57.3%	64.9%	N/A	N/A	71.1%	–	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 18 to 64 years)	1,245	517	41.5%	38.7%	44.3%	48.2%	–	50.5%	–	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 65 years and older)	3	2	N/A	N/A	N/A	N/A	N/A	46.7%	N/A	NA
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Ages 13 to 17 years)[4]	62	12	19.4%	8.7%	30.0%	N/A	N/A	24.6%	n.s.	NA
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Ages 18 to 64 years)[4]	3,563	1,289	36.2%	34.6%	37.8%	N/A	N/A	34.4%	+	NA
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Ages 65 years and older)[4]	5	1	N/A	N/A	N/A	N/A	N/A	20.6%	N/A	NA
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Ages 13 to 17 years)[4]	62	19	30.6%	18.4%	42.9%	N/A	N/A	36.4%	n.s.	NA
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Ages 18 to 64 years)[4]	3,563	1,806	50.7%	49.0%	52.3%	N/A	N/A	49.2%	n.s.	NA
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Ages 65 years and older)[4]	5	2	N/A	N/A	N/A	N/A	N/A	29.4%	N/A	NA
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase	1,778	592	33.3%	31.1%	35.5%	35.7%	n.s.	45.4%	–	≥ 10th and < 25th percentile
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase	449	196	43.7%	39.0%	48.4%	45.8%	n.s.	53.3%	–	≥ 10th and < 25th percentile
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase - BH Enhanced	1,938	635	32.8%	30.7%	34.9%	35.0%	n.s.	44.5%	–	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - BH Enhanced	484	213	44.0%	39.5%	48.5%	44.0%	n.s.	52.5%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years)	313	212	67.7%	62.4%	73.1%	63.8%	n.s.	75.6%	–	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years)	1,014	755	74.5%	71.7%	77.2%	70.3%	+	78.9%	–	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	1,327	967	72.9%	70.4%	75.3%	68.6%	+	78.0%	–	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 1 to 11 years)	313	209	66.8%	61.4%	72.1%	64.6%	n.s.	71.8%	n.s.	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years)	1,014	642	63.3%	60.3%	66.3%	61.7%	n.s.	68.1%	–	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	1,327	851	64.1%	61.5%	66.7%	62.4%	n.s.	69.2%	–	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years)	313	191	61.0%	55.5%	66.6%	58.3%	n.s.	68.8%	–	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years)	1,014	614	60.6%	57.5%	63.6%	58.2%	n.s.	66.2%	–	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	1,327	805	60.7%	58.0%	63.3%	58.3%	n.s.	66.9%	–	≥ 90th percentile
Pharmacotherapy for Opioid Use Disorder (Ages 16 to 64 years)	3,936	929	23.6%	22.3%	24.9%	21.6%	+	22.2%	n.s.	≥ 25th and < 50th percentile
Pharmacotherapy for Opioid Use Disorder (Ages 65 years and older)	7	2	N/A	N/A	N/A	16.7%	N/A	33.8%	N/A	NA
Pharmacotherapy for Opioid Use Disorder (Total)	3,943	931	23.6%	22.3%	24.9%	21.6%	+	22.3%	n.s.	≥ 25th and < 50th percentile
Screening for Depression and Follow-Up Plan (Ages 18 to 64 years)	127,507	792	0.6%	0.6%	0.7%	N/A	N/A	4.8%	–	NA
Screening for Depression and Follow-Up Plan (Ages 65 years and older)	3,728	46	1.2%	0.9%	1.6%	N/A	N/A	7.8%	–	NA
Screening for Depression and Follow-Up Plan (Total)	131,235	838	0.6%	0.6%	0.7%	N/A	N/A	4.9%	–	NA
Use of Pharmacotherapy for Opioid Use Disorder: Any Medication	646	451	69.8%	66.2%	73.4%	62.9%	+	76.2%	–	NA
Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine	646	437	67.6%	64.0%	71.3%	60.5%	+	71.3%	n.s.	NA
Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting Injectable Naltrexone	646	12	1.9%	0.7%	3.0%	2.7%	n.s.	3.2%	n.s.	NA
Use of Pharmacotherapy for Opioid Use Disorder: Methadone	646	5	0.8%	0.0%	1.5%	0.8%	n.s.	3.0%	–	NA
Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone	646	11	1.7%	0.6%	2.8%	1.7%	n.s.	2.5%	n.s.	NA

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
[3]The youngest age group expanded from ages 13-17 years in MY 2021 to ages 6-17 years in MY 2022. A year-to-year comparison is not applicable during this transition.
[4]The specification underwent severe changes in MY 2022. A year-to-year comparison is not applicable during this transition period.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Cardiovascular Conditions

The measures in the Cardiovascular Conditions category are listed in **Table 8**, followed by the measure data in **Table 9**.

Table 8: Cardiovascular Conditions Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Cardiac Rehabilitation	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members 18 years of age and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.	Rate 1: Initiation. The percentage of members who attended two or more sessions of cardiac rehabilitation within 30 days after a qualifying event. Rate 2: Engagement 1. The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event. Rate 3: Engagement 2. The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event. Rate 4: Achievement. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.	Ages 18–64 years, 65 years of age and older, and total ages
NCQA	Controlling High Blood Pressure	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18– 85 years who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled during the MY.	N/A	Ages 18–85 years
NCQA	Persistence of Beta-Blocker Treatment After a Heart Attack	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members age 18 years and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the MY to June 30 of the MY with a diagnosis of Acute Myocardial Infarction (AMI) and who received persistent beta-blocker treatment for 6 months after discharge.	N/A	18 years of age and older
NCQA	Statin Therapy for Patients With Cardiovascular Disease	-	Reported as HEDIS-audited measure	This measure assesses the percentage of males ages 21–75 years and females ages 40–75 years during the MY who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.	Rate 1: Received Statin Therapy. Members who were dispensed at least one high- or moderate-intensity statin medication during the MY. Rate 2: Statin Adherence 80%. Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.	Age groups vary by measure stratification

NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable.

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

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

Table 9: Cardiovascular Conditions Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Ages 18 to 64 years)	522	10	1.9%	0.6%	3.2%	1.3%	n.s.	2.8%	n.s.	≥ 25th and < 50th percentile
Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Ages 65 years and older)	8	0	N/A	N/A	N/A	16.7%	N/A	5.7%	N/A	NA
Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Total)	530	10	1.9%	0.6%	3.1%	1.6%	n.s.	2.9%	n.s.	≥ 25th and < 50th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Ages 18 to 64 years)	522	15	2.9%	1.3%	4.4%	2.4%	n.s.	3.9%	n.s.	≥ 25th and < 50th percentile
Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Ages 65 years and older)	8	0	N/A	N/A	N/A	25.0%	N/A	12.9%	N/A	NA
Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Total)	530	15	2.8%	1.3%	4.3%	2.8%	n.s.	4.2%	n.s.	≥ 25th and < 50th percentile
Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 18 to 64 years)	522	15	2.9%	1.3%	4.4%	1.5%	n.s.	3.7%	n.s.	≥ 25th and < 50th percentile
Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 65 years and older)	8	0	N/A	N/A	N/A	25.0%	N/A	14.3%	N/A	NA
Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	530	15	2.8%	1.3%	4.3%	1.9%	n.s.	3.9%	n.s.	≥ 25th and < 50th percentile
Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 18 to 64 years)	522	2	0.4%	-0.2%	1.0%	0.0%	n.s.	1.2%	n.s.	≥ 25th and < 50th percentile
Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 65 years and older)	8	0	N/A	N/A	N/A	0.0%	N/A	8.6%	N/A	NA
Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	530	2	0.4%	-0.2%	1.0%	0.0%	n.s.	1.3%	n.s.	≥ 25th and < 50th percentile
Controlling High Blood Pressure	411	271	65.9%	61.2%	70.6%	55.5%	+	70.3%	n.s.	≥ 50th and < 75th percentile
Persistence of Beta-Blocker Treatment After a Heart Attack	198	165	83.3%	77.9%	88.8%	83.2%	n.s.	85.3%	n.s.	≥ 50th and < 75th percentile
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Males ages 21 to 75 years)	1,308	1,085	83.0%	80.9%	85.0%	84.8%	n.s.	85.0%	n.s.	≥ 50th and < 75th percentile
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Females ages 40 to 75 years)	757	617	81.5%	78.7%	84.3%	78.4%	n.s.	83.1%	n.s.	≥ 50th and < 75th percentile
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	2,065	1,702	82.4%	80.8%	84.1%	82.5%	n.s.	84.2%	–	≥ 50th and < 75th percentile
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Males ages 21 to 75 years)	1,085	857	79.0%	76.5%	81.5%	77.6%	n.s.	78.0%	n.s.	≥ 75th and < 90th percentile
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Females ages 40 to 75 years)	617	480	77.8%	74.4%	81.2%	78.5%	n.s.	79.0%	n.s.	≥ 75th and < 90th percentile
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	1,702	1,337	78.6%	76.6%	80.5%	77.9%	n.s.	78.4%	n.s.	≥ 75th and < 90th percentile

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

[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Dental and Oral Health Services

The measures in the Dental and Oral Health Services category are listed in **Table 10**, followed by the measure data in **Table 11**.

Table 10: Dental and Oral Health Services Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
DQA (ADA)	Oral Evaluation - Dental Services	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of enrolled children under 21 years of age who received a comprehensive or periodic oral evaluation within the MY.	N/A	Younger than 1 year of age, ages 1–2 years, ages 3–5 years, ages 6–7 years, ages 8–9 years, ages 10–11 years, ages 12–14 years, ages 15–18 years, ages 19–20 years, and total ages
DQA (ADA)	Sealant Receipt on Permanent First Year Molars	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of enrolled children who have ever received sealants on permanent first molar teeth and turned 10 years old during the MY.	Rate 1: The percentage of enrolled children who received a sealant on at least one permanent first molar in the 48 months prior to their 10th birthday. Rate 2: The percentage of unduplicated enrolled children who received sealants on all four permanent first molars in the 48 months prior to their 10th birthday.	10 years of age during the MY
DQA (ADA)	Topical Fluoride for Children	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of enrolled children ages 1–20 years who received at least two topical fluoride applications.	Rate 1: Reported as dental or oral health services. Rate 2: Reported as dental services. Rate 3: Reported as oral health services.	Younger than 1 year of age, ages 1–2 years, ages 3–5 years, ages 6–7 years, ages 8–9 years, ages 10–11 years, ages 12–14 years, ages 15–18 years, ages 19–20 years, and total ages

DQA (ADA): Dental Quality Alliance (American Dental Association); CMS: Centers for Medicare and Medicaid Services; MY: measurement year; MCO: managed care organization; N/A: not applicable.

Strengths are identified for MY 2022 Dental and Oral Health Services performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Oral Evaluation - Dental Services (Ages 1 to 2 years) - 9.6 percentage points
  - Oral Evaluation - Dental Services (Ages 3 to 5 years) - 12.0 percentage points
  - Oral Evaluation - Dental Services (Ages 6 to 7 years) - 8.6 percentage points
  - Oral Evaluation - Dental Services (Ages 8 to 9 years) - 7.5 percentage points
  - Oral Evaluation - Dental Services (Ages 10 to 11 years) - 7.8 percentage points
  - Oral Evaluation - Dental Services (Age 12 to 14 years) - 8.4 percentage points
  - Oral Evaluation - Dental Services (Ages 15 to 18 years) - 6.9 percentage points
  - Oral Evaluation - Dental Services (Total) - 7.6 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 1 to 2 years) - 4.2 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 3 to 5 years) - 6.9 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 6 to 7 years) - 5.1 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 8 to 9 years) - 3.8 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 10 to 11 years) - 3.5 percentage points
  - Topical Fluoride for Children - Dental Services (Age 12 to 14 years) - 4.0 percentage points
  - Topical Fluoride for Children - Dental Services (Total) - 3.9 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Ages 1 to 2 years) - 4.2 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Ages 3 to 5 years) - 6.9 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Ages 6 to 7 years) - 5.0 percentage points

- Topical Fluoride for Children - Dental or Oral Health Services (Ages 8 to 9 years) - 3.7 percentage points
- Topical Fluoride for Children - Dental or Oral Health Services (Ages 10 to 11 years) - 3.4 percentage points
- Topical Fluoride for Children - Dental or Oral Health Services (Age 12 to 14 years) - 3.9 percentage points
- Topical Fluoride for Children - Dental or Oral Health Services (Total) - 3.8 percentage points

Opportunities for improvement are identified for MY 2022 Dental and Oral Health Services performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Sealant Receipt on Permanent First Year Molars - At Least One Sealant - 23.1 percentage points
  - Sealant Receipt on Permanent First Year Molars - All Four Molars Sealed - 16.2 percentage points

Table 11: Dental and Oral Health Services Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Oral Evaluation - Dental Services (Ages less than 1 year)	5,027	52	1.0%	0.7%	1.3%	1.0%	n.s.	1.2%	n.s.	NA
Oral Evaluation - Dental Services (Ages 1 to 2 years)	22,804	8,006	35.1%	34.5%	35.7%	36.1%	-	25.5%	+	NA
Oral Evaluation - Dental Services (Ages 3 to 5 years)	36,098	23,354	64.7%	64.2%	65.2%	65.5%	-	52.7%	+	NA
Oral Evaluation - Dental Services (Ages 6 to 7 years)	23,689	16,423	69.3%	68.7%	69.9%	70.3%	-	60.7%	+	NA
Oral Evaluation - Dental Services (Ages 8 to 9 years)	22,319	15,246	68.3%	67.7%	68.9%	68.2%	n.s.	60.8%	+	NA
Oral Evaluation - Dental Services (Ages 10 to 11 years)	23,183	15,131	65.3%	64.7%	65.9%	66.2%	-	57.5%	+	NA
Oral Evaluation - Dental Services (Age 12 to 14 years)	34,546	21,193	61.3%	60.8%	61.9%	63.1%	-	53.0%	+	NA
Oral Evaluation - Dental Services (Ages 15 to 18 years)	43,375	21,236	49.0%	48.5%	49.4%	50.4%	-	42.1%	+	NA
Oral Evaluation - Dental Services (Ages 19 to 20 years)	18,962	5,274	27.8%	27.2%	28.5%	30.3%	-	25.0%	+	NA
Oral Evaluation - Dental Services (Total)	230,003	125,915	54.7%	54.5%	54.9%	55.9%	-	47.1%	+	NA
Sealant Receipt on Permanent First Year Molars - At Least One Sealant	10,832	757	7.0%	6.5%	7.5%	18.3%	-	30.1%	-	NA
Sealant Receipt on Permanent First Year Molars - All Four Molars Sealed	10,832	399	3.7%	3.3%	4.0%	9.9%	-	19.9%	-	NA
Topical Fluoride for Children - Dental Services (Ages 1 to 2 years)	20,968	2,369	11.3%	10.9%	11.7%	11.7%	n.s.	7.1%	+	NA
Topical Fluoride for Children - Dental Services (Ages 3 to 5 years)	33,886	9,933	29.3%	28.8%	29.8%	30.1%	-	22.4%	+	NA
Topical Fluoride for Children - Dental Services (Ages 6 to 7 years)	22,312	7,232	32.4%	31.8%	33.0%	32.4%	n.s.	27.3%	+	NA
Topical Fluoride for Children - Dental Services (Ages 8 to 9 years)	20,998	6,369	30.3%	29.7%	31.0%	30.0%	n.s.	26.5%	+	NA
Topical Fluoride for Children - Dental Services (Ages 10 to 11 years)	21,862	6,005	27.5%	26.9%	28.1%	27.9%	n.s.	24.0%	+	NA
Topical Fluoride for Children - Dental Services (Age 12 to 14 years)	32,572	7,840	24.1%	23.6%	24.5%	24.7%	-	20.1%	+	NA
Topical Fluoride for Children - Dental Services (Ages 15 to 18 years)	40,765	4,730	11.6%	11.3%	11.9%	11.7%	n.s.	9.1%	+	NA
Topical Fluoride for Children - Dental Services (Ages 19 to 20 years)	17,153	79	0.5%	0.4%	0.6%	0.5%	n.s.	0.4%	+	NA
Topical Fluoride for Children - Dental Services (Total)	210,516	44,557	21.2%	21.0%	21.3%	21.6%	-	17.3%	+	NA
Topical Fluoride for Children - Oral Health Services (Ages 1 to 2 years)	20,968	1,548	7.4%	7.0%	7.7%	8.2%	-	6.7%	+	NA
Topical Fluoride for Children - Oral Health Services (Ages 3 to 5 years)	33,886	200	0.6%	0.5%	0.7%	0.6%	n.s.	0.6%	n.s.	NA
Topical Fluoride for Children - Oral Health Services (Ages 6 to 7 years)	22,312	2	0.0%	0.0%	0.0%	0.0%	n.s.	0.0%	n.s.	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Topical Fluoride for Children - Oral Health Services (Ages 8 to 9 years)	20,998	1	0.0%	0.0%	0.0%	0.0%	n.s.	0.0%	n.s.	NA
Topical Fluoride for Children - Oral Health Services (Ages 10 to 11 years)	21,862	0	0.0%	N/A	N/A	0.0%	n.s.	0.0%	N/A	NA
Topical Fluoride for Children - Oral Health Services (Age 12 to 14 years)	32,572	0	0.0%	N/A	N/A	0.0%	n.s.	0.0%	N/A	NA
Topical Fluoride for Children - Oral Health Services (Ages 15 to 18 years)	40,765	0	0.0%	N/A	N/A	0.0%	n.s.	0.0%	N/A	NA
Topical Fluoride for Children - Oral Health Services (Ages 19 to 20 years)	17,153	0	0.0%	N/A	N/A	0.0%	n.s.	N/A	N/A	NA
Topical Fluoride for Children - Oral Health Services (Total)	210,516	1,751	0.8%	0.8%	0.9%	1.0%	-	0.8%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 1 to 2 years)	20,968	4,554	21.7%	21.2%	22.3%	23.5%	-	17.5%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 3 to 5 years)	33,886	11,069	32.7%	32.2%	33.2%	33.9%	-	25.7%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 6 to 7 years)	22,312	7,274	32.6%	32.0%	33.2%	32.6%	n.s.	27.6%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 8 to 9 years)	20,998	6,378	30.4%	29.7%	31.0%	30.0%	n.s.	26.7%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 10 to 11 years)	21,862	6,021	27.5%	26.9%	28.1%	28.0%	n.s.	24.2%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Age 12 to 14 years)	32,572	7,866	24.1%	23.7%	24.6%	24.8%	-	20.2%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 15 to 18 years)	40,765	4,753	11.7%	11.3%	12.0%	11.7%	n.s.	9.2%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 19 to 20 years)	17,153	79	0.5%	0.4%	0.6%	0.5%	n.s.	0.4%	n.s.	NA
Topical Fluoride for Children - Dental or Oral Health Services (Total)	210,516	47,994	22.8%	22.6%	23.0%	23.5%	-	19.0%	+	NA

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

[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "−" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Diabetes

The measures in the Diabetes category are listed in **Table 12**, followed by the measure data in **Table 13**.

Table 12: Diabetes Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Blood Pressure Control for Patients With Diabetes	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–75 years with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the MY. This measure was formally part of the retired HEDIS Comprehensive Diabetes Care Measure.	N/A	Ages 18–75 years
NCQA	Eye Exam for Patients With Diabetes	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–75 years with diabetes (types 1 and 2) who had a retinal eye exam. This measure was formally part of the retired HEDIS Comprehensive Diabetes Care Measure.	N/A	Ages 18–75 years
NCQA	Hemoglobin A1c (HbA1c) Control for Patients With Diabetes	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–75 years with diabetes (types 1 and 2) whose HbA1c was < 8.0% (control) and > 9.0% (poor control). A higher rate is better for < 8.0% (control), whereas a lower rate is better for > 9.0% (poor control). This measure was formally part of the retired HEDIS Comprehensive Diabetes Care Measure.	Rate 1: HbA1c was < 8.0% (control). Rate 2: HbA1c was > 9.0% (poor control).	Ages 18–75 years
NCQA	Kidney Health Evaluation for Patients With Diabetes	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–85 years with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the MY.	N/A	Ages 18–64 years, ages 65–74 years, ages 75–85 years, and total ages
NCQA	Statin Therapy for Patients With Diabetes	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 40–75 years during the MY with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who received and adhered to statin therapy.	Rate 1: Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the MY. Rate 2: Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	Ages 40–75 years

NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable.

No strengths are identified for MY 2022 Diabetes performance measures.

Opportunities for improvement are identified for MY 2022 Diabetes performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Blood Pressure Control for Patients With Diabetes - 6.5 percentage points
  - Eye Exam for Patients With Diabetes - 8.8 percentage points
  - Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (< 8%) - 5.8 percentage points

Table 13: Diabetes Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Blood Pressure Control for Patients With Diabetes	411	266	64.7%	60.0%	69.5%	59.9%	n.s.	71.2%	–	≥ 50th and < 75th percentile
Eye Exam for Patients With Diabetes	411	202	49.2%	44.2%	54.1%	53.8%	n.s.	57.9%	–	≥ 25th and < 50th percentile
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (< 8%)	411	215	52.3%	47.4%	57.3%	51.1%	n.s.	58.1%	–	≥ 50th and < 75th percentile
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control (> 9.0%)	411	149	36.3%	31.5%	41.0%	42.1%	n.s.	32.3%	n.s.	≥ 50th and < 75th percentile
Kidney Health Evaluation for Patients With Diabetes (Ages 18 to 64 years)	17,589	7,722	43.9%	43.2%	44.6%	42.7%	+	45.4%	–	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Kidney Health Evaluation for Patients With Diabetes (Ages 65 to 74 years)	618	320	51.8%	47.8%	55.8%	49.5%	n.s.	53.4%	n.s.	≥ 75th and < 90th percentile
Kidney Health Evaluation for Patients With Diabetes (Ages 75 to 85 years)	212	107	50.5%	43.5%	57.4%	50.9%	n.s.	51.2%	n.s.	≥ 75th and < 90th percentile
Kidney Health Evaluation for Patients With Diabetes (Total)	18,419	8,149	44.2%	43.5%	45.0%	43.0%	+	45.9%	–	≥ 75th and < 90th percentile
Statin Therapy for Patients With Diabetes - Received Statin Therapy	10,643	7,546	70.9%	70.0%	71.8%	70.0%	n.s.	70.3%	n.s.	≥ 75th and < 90th percentile
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	7,546	5,716	75.8%	74.8%	76.7%	73.8%	+	75.0%	n.s.	≥ 75th and < 90th percentile

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Electronic Clinical Data Systems

The measures in the ECDS category are listed in **Table 14**, followed by the measure data in **Table 15**.

Table 14: Electronic Clinical Data Systems Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Adult Immunization Status	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 19–65 years who are up-to-date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (TDaP), zoster, and pneumococcal. This measure is calculated using electronic clinical data.	N/A	Ages 19–65 years
NCQA	Breast Cancer Screening	-	Reported as HEDIS-audited measure	This measure assesses the percentage of women ages 50–74 years who had a mammogram to screen for breast cancer. This measure is calculated using electronic clinical data.	N/A	Ages 50–74 years
NCQA	Childhood Immunization Status	-	Reported as HEDIS-audited measure	This measure assesses the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. This measure is calculated using electronic clinical data.	The measure calculates a rate for each vaccine and three combination rates. Combination 3 includes vaccinations for DTap, IPV, MMR, HiB, HepB, VZV, and PCV. Combination 7 includes vaccinations for DTap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, and RV. Combination 10 includes vaccinations for DTap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and influenza.	2 years of age
NCQA	Colorectal Cancer Screening	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 46–75 years who had appropriate screening for colorectal cancer. This measure is calculated using electronic clinical data.	N/A	Ages 46–49 years, ages 50–75 years, and total ages
NCQA	Depression Screening and Follow-Up for Adolescents and Adults	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. This measure is calculated using electronic clinical data.	Rate 1: Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. Rate 2: Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.	Ages 12–17 years, 18–64 years, and 65 years of age and older

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	-	Reported as HEDIS-audited measure	This measure assesses the percentage of children newly prescribed 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. This measure is calculated using electronic clinical data.	Rate 1: Initiation Phase. The percentage of members ages 6–12 years as of the index prescription start date with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. Rate 2: Continuation and Maintenance Phase. The percentage of members 6–12 years of age as of the index prescription start date (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.	Ages 6–12 years
NCQA	Immunizations for Adolescents	-	Reported as HEDIS-audited measure	This measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (TDaP) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. This measure is calculated using electronic clinical data.	The measure calculates a rate for each vaccine and two combination rates. Combination 1 includes the meningococcal and TDaP vaccine, and Combination 2 includes all three vaccinations.	13 years of age
NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics	-	Reported as HEDIS-audited measure	This measure assesses the percentage of children and adolescents ages 1–17 years who had two or more antipsychotic prescriptions and had metabolic testing. This measure is calculated using electronic clinical data.	Rate 1: The percentage of children and adolescents on antipsychotics who received blood glucose testing. Rate 2: The percentage of children and adolescents on antipsychotics who received cholesterol testing. Rate 3: The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	Ages 1–11 years, ages 12–17 years, and total ages
NCQA	Postpartum Depression Screening and Follow-Up	-	Reported as HEDIS-audited measure	This measure assesses the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care. This measure is calculated using electronic clinical data.	Rate 1: Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. Rate 2: Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	All member ages
NCQA	Prenatal Depression Screening and Follow-Up	-	Reported as HEDIS-audited measure	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. This measure is calculated using electronic clinical data.	Rate 1: Depression Screening. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. Rate 2: Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding	All member ages
NCQA	Prenatal Immunization Status	-	Reported as HEDIS-audited measure	The percentage of deliveries in the measurement period in which women had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (TDaP) vaccinations. This measure is calculated using electronic clinical data.	N/A	All member ages

NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable.

Strengths are identified for MY 2022 ECDS performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Childhood Immunization Status - Influenza - 7.4 percentage points
  - Childhood Immunization Status - Combo 10 - 7.0 percentage points
  - Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 12 to 17 years) - 13.9 percentage points
  - Immunizations for Adolescents - HPV - 6.8 percentage points
  - Immunizations for Adolescents - Combination 2 - 6.7 percentage points
  - Prenatal Depression Screening and Follow-Up - Depression Screening - 12.8 percentage points
  - Postpartum Depression Screening and Follow-Up - Depression Screening - 9.5 percentage points

Opportunities for improvement are identified for MY 2022 ECDS performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Adult Immunization Status - Td/TDaP (Ages 19 to 65 years) - 6.7 percentage points
  - Colorectal Cancer Screening (Ages 50 to 75 years) - 5.7 percentage points
  - Colorectal Cancer Screening (Total) - 5.1 percentage points
  - Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase - 12.1 percentage points
  - Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - 9.9 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years) - 7.8 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years) - 4.4 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) - 5.0 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years) - 4.8 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) - 5.1 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years) - 7.8 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years) - 5.6 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) - 6.2 percentage points
  - Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen - 11.7 percentage points

Table 15: Electronic Clinical Data Systems Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Adult Immunization Status - Influenza (Ages 19 to 65 years)	196,642	34,896	17.8%	17.6%	17.9%	21.0%	–	16.8%	+	≥ 50th and < 75th percentile
Adult Immunization Status - Td/TDaP (Ages 19 to 65 years)	196,642	77,129	39.2%	39.0%	39.4%	37.2%	+	45.9%	–	≥ 50th and < 75th percentile
Adult Immunization Status - Zoster (Ages 50 to 65 years)	40,367	4,430	11.0%	10.7%	11.3%	8.4%	+	11.4%	–	≥ 50th and < 75th percentile
Breast Cancer Screening	17,555	9,357	53.3%	52.6%	54.0%	49.5%	+	55.0%	–	≥ 50th and < 75th percentile
Childhood Immunization Status - DTaP	10,752	7,750	72.1%	71.2%	72.9%	N/A	N/A	70.8%	+	NA
Childhood Immunization Status - Hepatitis A	10,752	9,186	85.4%	84.8%	86.1%	N/A	N/A	83.3%	+	NA
Childhood Immunization Status - Hepatitis B	10,752	9,206	85.6%	85.0%	86.3%	N/A	N/A	85.0%	n.s.	NA
Childhood Immunization Status - HiB	10,752	9,272	86.2%	85.6%	86.9%	N/A	N/A	84.4%	+	NA
Childhood Immunization Status - Influenza	10,752	5,601	52.1%	51.1%	53.0%	N/A	N/A	44.7%	+	NA
Childhood Immunization Status - IPV	10,752	9,245	86.0%	85.3%	86.6%	N/A	N/A	85.5%	n.s.	NA
Childhood Immunization Status - MMR	10,752	9,361	87.1%	86.4%	87.7%	N/A	N/A	86.4%	n.s.	NA
Childhood Immunization Status - Pneumococcal Conjugate	10,752	7,839	72.9%	72.1%	73.8%	N/A	N/A	73.2%	n.s.	NA
Childhood Immunization Status - Rotavirus	10,752	7,551	70.2%	69.4%	71.1%	N/A	N/A	68.7%	+	NA
Childhood Immunization Status - VZV	10,752	9,363	87.1%	86.4%	87.7%	N/A	N/A	86.1%	+	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Childhood Immunization Status - Combo 7	10,752	6,233	58.0%	57.0%	58.9%	N/A	N/A	55.2%	+	NA
Childhood Immunization Status - Combo 3	10,752	7,130	66.3%	65.4%	67.2%	N/A	N/A	64.3%	+	NA
Childhood Immunization Status - Combo 10	10,752	4,245	39.5%	38.6%	40.4%	N/A	N/A	32.5%	+	NA
Colorectal Cancer Screening (Ages 46 to 49 years)	11,273	2,089	18.5%	17.8%	19.3%	N/A	N/A	20.9%	–	NA
Colorectal Cancer Screening (Ages 50 to 75 years)	41,309	15,441	37.4%	36.9%	37.8%	N/A	N/A	43.1%	–	NA
Colorectal Cancer Screening (Total)	52,582	17,530	33.3%	32.9%	33.7%	N/A	N/A	38.4%	–	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 12 to 17 years)	56,847	764	1.3%	1.2%	1.4%	0.2%	+	2.8%	–	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 18 to 64 years)	180,810	7,399	4.1%	4.0%	4.2%	2.4%	+	3.7%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 65 years and older)	2,668	46	1.7%	1.2%	2.2%	0.6%	+	2.5%	–	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)	240,325	8,209	3.4%	3.3%	3.5%	1.9%	+	3.5%	–	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 12 to 17 years)	68	50	73.5%	62.3%	84.8%	57.1%	N/A	59.6%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 18 to 64 years)	504	312	61.9%	57.6%	66.2%	42.2%	+	61.5%	n.s.	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 65 years and older)	1	0	N/A	N/A	N/A	N/A	N/A	40.7%	N/A	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)	573	362	63.2%	59.1%	67.2%	42.6%	+	62.4%	n.s.	NA
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase	1,780	592	33.3%	31.0%	35.5%	35.4%	n.s.	45.3%	–	NA
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase	450	195	43.3%	38.6%	48.0%	44.3%	n.s.	53.2%	–	NA
Immunizations for Adolescents - HPV	10,773	4,899	45.5%	44.5%	46.4%	N/A	N/A	38.7%	+	NA
Immunizations for Adolescents - Meningococcal	10,773	9,350	86.8%	86.1%	87.4%	N/A	N/A	85.1%	+	NA
Immunizations for Adolescents - TDaP	10,773	9,417	87.4%	86.8%	88.0%	N/A	N/A	85.7%	+	NA
Immunizations for Adolescents - Combination 1	10,773	9,256	85.9%	85.3%	86.6%	N/A	N/A	84.2%	+	NA
Immunizations for Adolescents - Combination 2	10,773	4,809	44.6%	43.7%	45.6%	N/A	N/A	38.0%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years)	313	212	67.7%	62.4%	73.1%	N/A	N/A	75.6%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years)	1,014	755	74.5%	71.7%	77.2%	N/A	N/A	78.8%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	1,327	967	72.9%	70.4%	75.3%	N/A	N/A	77.9%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 1 to 11 years)	313	209	66.8%	61.4%	72.1%	N/A	N/A	71.8%	n.s.	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years)	1,014	642	63.3%	60.3%	66.3%	N/A	N/A	68.1%	–	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	1,327	851	64.1%	61.5%	66.7%	N/A	N/A	69.2%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years)	313	191	61.0%	55.5%	66.6%	N/A	N/A	68.8%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years)	1,014	614	60.6%	57.5%	63.6%	N/A	N/A	66.1%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	1,327	805	60.7%	58.0%	63.3%	N/A	N/A	66.9%	–	NA
Prenatal Depression Screening and Follow-Up - Depression Screening	6,588	2,924	44.4%	43.2%	45.6%	40.0%	+	31.6%	+	≥ 90th percentile
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen	228	104	45.6%	38.9%	52.3%	46.9%	n.s.	50.8%	n.s.	≥ 25th and < 50th percentile
Postpartum Depression Screening and Follow-Up - Depression Screening	7,762	3,102	40.0%	38.9%	41.1%	20.9%	+	30.5%	+	≥ 90th percentile
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen	129	62	48.1%	39.1%	57.1%	46.8%	n.s.	59.7%	–	≥ 10th and < 25th percentile
Prenatal Immunization Status - Influenza	6,594	2,141	32.5%	31.3%	33.6%	35.9%	–	30.3%	+	≥ 75th and < 90th percentile
Prenatal Immunization Status - TDaP	6,594	4,403	66.8%	65.6%	67.9%	65.6%	n.s.	68.3%	–	≥ 50th and < 75th percentile
Prenatal Immunization Status - Combination	6,594	1,865	28.3%	27.2%	29.4%	30.6%	–	26.8%	+	≥ 75th and < 90th percentile

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Maternal and Perinatal Health

The measures in the Maternal and Perinatal Health category are listed in **Table 16**, followed by the measure data in **Table 17**.

Table 16: Maternal and Perinatal Health Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
OPA	Contraceptive Care - All Women	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of women ages 15–44 years at risk of unintended pregnancy who were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC).	Rate 1: Provision of most or moderately effective contraception. Rate 2: Provision of LARC.	Ages 15–20 years and ages 21–44 years
OPA	Contraceptive Care - Postpartum Women	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of women ages 15–44 years who had a live birth and were provided a most effective/moderately effective contraception method or a LARC within 3 days and within 60 days of delivery.	Rate 1: Most or moderately effective contraception – 3 days Rate 2: Most or moderately effective contraception – 60 days Rate 3: LARC – 3 days Rate 4: LARC – 60 days.	Ages 15–20 years and ages 21–44 years

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
PA DHS	Perinatal Depression Screening	-	Measure is calculated by IPRO	This measure assesses the percentage of women screened for depression and provided further treatment during perinatal care. This measure uses components of the HEDIS MY 2022 Prenatal and Postpartum Care Health Plan measure.	Rate 1: Screened for depression during a prenatal care visit. Rate 2: Screened for depression during a prenatal care visit using a validated depression screening tool. Rate 3: Screened for depression during the time frame of the first two prenatal care visits (Children's Health Insurance Program Reauthorization act (CHIPRA) indicator). Rate 4: Screened positive for depression during a prenatal care visit. Rate 5: Screened positive for depression during a prenatal care visit and had evidence of further evaluation, treatment, or referral for further treatment. Rate 6: Screened for depression during a postpartum care visit. Rate 7: Screened for depression during a postpartum care visit using a validated depression screening tool. Rate 8: Screened positive for depression during a postpartum care visit. Rate 9: Screened positive for depression during a postpartum care visit and had evidence of further evaluation, treatment, or referral for further treatment.	All member ages
PA DHS	Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit	-	Measure is calculated by IPRO	This measure assesses the percentage of women screened for smoking and provided further treatment during perinatal care. This measure uses components of the HEDIS MY 2022 Prenatal and Postpartum Care Health Plan measure.	Rate 1: Screened for smoking during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the MCO. Rate 2: Screened for smoking during the time frame of one of their first two prenatal visits (CHIPRA indicator). Rate 3: Screened for environmental tobacco smoke exposure during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the MCO. Rate 4: Screened for smoking in one of their first two prenatal visits for members who smoke (i.e., smoked six months prior to or anytime during the current pregnancy), that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy. Rate 5: Screened for environmental tobacco smoke exposure in one of their first two prenatal visits and found to be exposed, that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy. Rate 6: Screened for smoking in one of their first two prenatal visits and found to be current smokers (i.e., smoked at the time of one of their first two prenatal visits) that stopped smoking during their pregnancy.	All member ages

OPA: U.S. Office of Population Affairs; PA DHS: Pennsylvania Department of Human Services; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MCO: managed care organization; MY: measurement year.

Strengths are identified for MY 2022 Maternal and Perinatal Health performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 3 Days of Delivery (Ages 15 to 20 years) - 6.5 percentage points
  - Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 3 Days of Delivery (Ages 21 to 44 years) - 3.2 percentage points
  - Perinatal Depression Screening: Screened for depression during a prenatal care visit - 5.9 percentage points
  - Perinatal Depression Screening: Screened for depression during the time frame of the first two prenatal care visits (CHIPRA Indicator) – 6.0 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking - 7.1 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) - 6.8 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS) - 9.3 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation - 22.0 percentage points

Opportunities for improvement are identified for MY 2022 Maternal and Perinatal Health performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Contraceptive Care - All Women - Most or Moderately Effective Contraception (Ages 15 to 20 years) - 5.5 percentage points
  - Perinatal Depression Screening: Screened for depression during a postpartum care visit - 4.9 percentage points
  - Perinatal Depression Screening: Screened positive for depression during a postpartum care visit - 4.8 percentage points
  - Perinatal Depression Screening: Screened positive for depression during a postpartum care visit and had evidence of further evaluation or treatment or referral for further treatment - 16.1 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking - 21.2 percentage points

Table 17: Maternal and Perinatal Health Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Contraceptive Care - All Women - Most or Moderately Effective Contraception (Ages 15 to 20 years)	27,447	6,138	22.4%	21.9%	22.9%	24.1%	–	27.9%	–	NA
Contraceptive Care - All Women - Most or Moderately Effective Contraception (Ages 21 to 44 years)	74,205	19,363	26.1%	25.8%	26.4%	27.3%	–	25.9%	n.s.	NA
Contraceptive Care - All Women - Long-Acting Reversible Method of Contraception (LARC) (Ages 15 to 20 years)	27,447	650	2.4%	2.2%	2.5%	2.6%	n.s.	3.0%	–	NA
Contraceptive Care - All Women - Long-Acting Reversible Method of Contraception (LARC) (Ages 21 to 44 years)	74,205	2,768	3.7%	3.6%	3.9%	3.9%	n.s.	3.8%	n.s.	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 3 Days of Delivery (Ages 15 to 20 years)	478	106	22.2%	18.3%	26.0%	23.5%	n.s.	15.6%	+	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 3 Days of Delivery (Ages 21 to 44 years)	5,204	1,155	22.2%	21.1%	23.3%	20.5%	+	19.0%	+	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 90 Days of Delivery (Ages 15 to 20 years)	478	263	55.0%	50.5%	59.6%	47.1%	+	53.6%	n.s.	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 90 Days of Delivery (Ages 21 to 44 years)	5,204	2,551	49.0%	47.7%	50.4%	43.1%	+	49.6%	n.s.	NA
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 3 Days of Delivery (Ages 15 to 20 years)	478	53	11.1%	8.2%	14.0%	13.5%	n.s.	8.5%	n.s.	NA
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 3 Days of Delivery (Ages 21 to 44 years)	5,204	425	8.2%	7.4%	8.9%	7.1%	+	5.9%	+	NA
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 90 Days of Delivery (Ages 15 to 20 years)	478	93	19.5%	15.8%	23.1%	17.7%	n.s.	19.2%	n.s.	NA
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 90 Days of Delivery (Ages 21 to 44 years)	5,204	813	15.6%	14.6%	16.6%	12.1%	+	14.7%	n.s.	NA
Perinatal Depression Screening: Screened for depression during a prenatal care visit	424	390	92.0%	89.3%	94.7%	78.8%	+	86.1%	+	NA
Perinatal Depression Screening: Screened for depression during a prenatal care visit using a validated depression screening tool	424	250	59.0%	54.2%	63.8%	57.8%	n.s.	56.5%	n.s.	NA
Perinatal Depression Screening: Screened for depression during the time frame of the first two prenatal care visits (CHIPRA Indicator)	424	352	83.0%	79.3%	86.7%	67.0%	+	77.0%	+	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Perinatal Depression Screening: Screened positive for depression during a prenatal care visit	390	73	18.7%	14.7%	22.7%	15.3%	n.s.	21.7%	n.s.	NA
Perinatal Depression Screening: Screened positive for depression during a prenatal care visit and had evidence of further evaluation or treatment or referral for further treatment	73	54	74.0%	63.2%	84.7%	64.7%	n.s.	82.0%	n.s.	NA
Perinatal Depression Screening: Screened for depression during a postpartum care visit	359	292	81.3%	77.2%	85.5%	76.2%	n.s.	86.2%	–	NA
Perinatal Depression Screening: Screened for depression during a postpartum care visit using a validated depression screening tool	359	249	69.4%	64.5%	74.3%	60.0%	+	73.2%	n.s.	NA
Perinatal Depression Screening: Screened positive for depression during a postpartum care visit	292	42	14.4%	10.2%	18.6%	14.8%	n.s.	19.2%	–	NA
Perinatal Depression Screening: Screened positive for depression during a postpartum care visit and had evidence of further evaluation or treatment or referral for further treatment	42	31	73.8%	59.3%	88.3%	79.5%	n.s.	89.8%	–	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking	424	392	92.5%	89.8%	95.1%	80.9%	+	85.4%	+	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	424	389	91.7%	89.0%	94.5%	79.7%	+	84.9%	+	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS)	424	275	64.9%	60.2%	69.5%	54.2%	+	55.6%	+	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking	61	28	45.9%	32.6%	59.2%	53.9%	n.s.	67.1%	–	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke Exposure (ETS)	16	10	N/A	N/A	N/A	57.1%	N/A	76.2%	N/A	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation	58	27	46.6%	32.9%	60.3%	54.7%	n.s.	24.6%	+	NA

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

[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Overuse/Appropriateness

The measures in the Overuse/Appropriateness category are listed in **Table 18**, followed by the measure data in **Table 19**.

Table 18: Overuse/Appropriateness Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Appropriate Treatment for Upper Respiratory Infection	-	Reported as HEDIS-audited measure	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).	N/A	Ages 3 months–17 years, ages 18–64 years, 65 years of age and older, and total ages

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of episodes for members 3 months of age 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).	N/A	Ages 3 months–17 years, ages 18–64 years, 65 years of age and older, and total ages
PQA	Concurrent Use of Opioids and Benzodiazepines	✓	Measure is calculated by the MCO and validated by IPRO	This performance measure assesses the percentage of members 18 years of age and above with concurrent use of prescription opioids and benzodiazepines. A lower rate indicates better performance.	N/A	Ages 18–64 years, 65 years of age and older, and 18 years of age and older
NCQA	Non-Recommended Cervical Cancer Screening in Adolescent Females	-	Reported as HEDIS-audited measure	This measure assesses the percentage of adolescent females ages 16–20 years who were screened unnecessarily for cervical cancer. A lower rate indicates better performance.	N/A	Ages 16–20 years
NCQA	Risk of Continued Opioid Use	-	Reported as HEDIS-audited measure	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. A lower rate indicates better performance.	Rate 1: The percentage of members with at least 15 days of prescription opioids in a 30-day period. Rate 2: The percentage of members with at least 31 days of prescription opioids in a 62-day period.	Ages 18–64 years, 65 years of age and older, and total ages
NCQA	Use of Imaging Studies for Low Back Pain	-	Reported as HEDIS-audited measure	The percentage of members ages 18–75 years with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	N/A	Ages 18–64 years, ages 65–75 years, and total ages
NCQA	Use of Opioids at High Dosage	-	Reported as HEDIS-audited measure	This measure assesses the proportion of members 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for greater than or equal to 15 days during the MY. A lower rate indicates better performance.	N/A	18 years of age and older
NCQA	Use of Opioids From Multiple Providers	-	Reported as HEDIS-audited measure	This measure assesses the proportion of members 18 years of age and older who received prescription opioids for greater than or equal to 15 days during the MY and who received opioids from multiple providers. A lower rate indicates better performance.	Rate 1: Multiple Prescribers. The proportion of members receiving prescriptions for opioids from four or more different prescribers during the MY. Rate 2: Multiple Pharmacies. The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the MY. Rate 3: 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 MY (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).	18 years of age and older

NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MCO: managed care organization; MY: measurement year; N/A: not applicable; PQA: Pharmacy Quality Alliance.

Strengths are identified for MY 2022 Overuse/Appropriateness performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months to 17 years) - 7.0 percentage points
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total) - 8.0 percentage points
  - Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 65 years and older) - 10.8 percentage points
  - Use of Imaging Studies for Low Back Pain (Age 18 to 64 years) - 3.7 percentage points
  - Use of Imaging Studies for Low Back Pain (Total) - 3.7 percentage points
  - Use of Opioids From Multiple Providers - Multiple Prescribers - 4.7 percentage points

Opportunities for improvement are identified for MY 2022 Overuse/Appropriateness performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Appropriate Treatment for Upper Respiratory Infection (Ages 18 to 64 years) - 6.2 percentage points
  - Use of Opioids at High Dosage - 9.7 percentage points

Table 19: Overuse/Appropriateness Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Appropriate Treatment for Upper Respiratory Infection (Ages 3 months to 17 years)	27,409	655	97.6%	97.4%	97.8%	97.6%	n.s.	95.1%	+	≥ 90th percentile
Appropriate Treatment for Upper Respiratory Infection (Ages 18 to 64 years)	5,581	1,188	78.7%	77.6%	79.8%	79.7%	n.s.	84.9%	–	≥ 25th and < 50th percentile
Appropriate Treatment for Upper Respiratory Infection (Ages 65 years and older)	73	19	74.0%	63.2%	84.7%	89.4%	–	72.3%	n.s.	≥ 50th and < 75th percentile
Appropriate Treatment for Upper Respiratory Infection (Total)	33,063	1,862	94.4%	94.1%	94.6%	93.2%	+	92.5%	+	≥ 75th and < 90th percentile
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months to 17 years)	2,388	355	85.1%	83.7%	86.6%	90.7%	–	78.2%	+	≥ 75th and < 90th percentile
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18 to 64 years)	1,037	507	51.1%	48.0%	54.2%	51.4%	n.s.	50.5%	n.s.	≥ 75th and < 90th percentile
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65 years and older)	17	9	N/A	N/A	N/A	66.7%	N/A	36.3%	N/A	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	3,442	871	74.7%	73.2%	76.2%	73.0%	n.s.	66.7%	+	≥ 75th and < 90th percentile
Concurrent Use of Opioids and Benzodiazepines (Ages 18 to 64 years)	2,341	431	18.4%	16.8%	20.0%	20.5%	n.s.	16.4%	+	NA
Concurrent Use of Opioids and Benzodiazepines (Ages 65 years and older)	19	4	N/A	N/A	N/A	N/A	N/A	18.5%	N/A	NA
Concurrent Use of Opioids and Benzodiazepines (Total)	2,360	435	18.4%	16.8%	20.0%	20.5%	n.s.	16.6%	+	NA
Non-Recommended Cervical Cancer Screening in Adolescent Females	22,909	22	0.1%	0.1%	0.1%	0.2%	n.s.	0.2%	–	≥ 75th and < 90th percentile
Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 18 to 64 years)	16,868	490	2.9%	2.6%	3.2%	2.3%	+	3.7%	–	≥ 75th and < 90th percentile
Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 65 years and older)	101	4	4.0%	-0.3%	8.3%	0.9%	n.s.	14.8%	–	≥ 90th percentile
Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Total)	16,969	494	2.9%	2.7%	3.2%	2.3%	+	3.9%	–	≥ 75th and < 90th percentile
Risk of Continued Opioid Use - At Least 31 Days of prescription Opioids in a 62-day Period (Ages 18 to 64 years)	16,868	412	2.4%	2.2%	2.7%	1.9%	+	2.5%	n.s.	≥ 50th and < 75th percentile
Risk of Continued Opioid Use - At Least 31 Days of prescription Opioids in a 62-day Period (Ages 65 years and older)	101	4	4.0%	-0.3%	8.3%	0.9%	n.s.	7.7%	n.s.	≥ 75th and < 90th percentile
Risk of Continued Opioid Use - At Least 31 Days of prescription Opioids in a 62-day Period (Total)	16,969	416	2.5%	2.2%	2.7%	1.9%	+	2.6%	n.s.	≥ 50th and < 75th percentile
Use of Imaging Studies for Low Back Pain (Age 18 to 64 years)	6,086	1,250	79.5%	78.4%	80.5%	81.0%	n.s.	75.7%	+	≥ 75th and < 90th percentile
Use of Imaging Studies for Low Back Pain (Ages 65 to 75 years)	85	20	76.5%	66.9%	86.1%	N/A	N/A	73.3%	n.s.	≥ 50th and < 75th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Use of Imaging Studies for Low Back Pain (Total)	6,171	1,270	79.4%	78.4%	80.4%	N/A	N/A	75.7%	+	≥ 75th and < 90th percentile
Use of Opioids at High Dosage	2,180	383	17.6%	15.9%	19.2%	17.9%	n.s.	7.9%	+	NA
Use of Opioids From Multiple Providers - Multiple Prescribers	2,724	299	11.0%	9.8%	12.2%	9.0%	+	15.7%	–	≥ 90th percentile
Use of Opioids From Multiple Providers - Multiple Pharmacies	2,724	32	1.2%	0.7%	1.6%	1.4%	n.s.	1.4%	n.s.	≥ 75th and < 90th percentile
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	2,724	14	0.5%	0.2%	0.8%	0.6%	n.s.	0.8%	n.s.	≥ 75th and < 90th percentile

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Prevention and Screening

The measures in the Prevention and Screening category are listed in **Table 20**, followed by the measure data in **Table 21**.

Table 20: Prevention and Screening Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Breast Cancer Screening	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of women ages 50–74 years who had a mammogram to screen for breast cancer.	N/A	Ages 50–74 years
NCQA	Cervical Cancer Screening	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of women ages 21–64 years who were screened for cervical cancer using any of the following criteria: women ages 21–64 years who had cervical cytology performed within the last 3 years; women ages 30–64 years who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years; or women ages 30–64 years who had cervical cytology/hrHPV co-testing within the last 5 years.	N/A	Ages 21–64 years
NCQA	Childhood Immunization Status	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	The measure calculates a rate for each vaccine and three combination rates. Combination 3 includes vaccinations for DTap, IPV, MMR, HiB, HepB, VZV, and PCV. Combination 7 includes vaccinations for DTap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, and RV. Combination 10 includes vaccinations for DTap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and influenza.	2 years of age
NCQA	Chlamydia Screening in Women	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of women ages 16–24 years who were identified as sexually active and who had at least one test for chlamydia during the MY.	N/A	Ages 16–20 years, ages 21–24 years, and total ages
NCQA	Colorectal Cancer Screening	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 46–75 years who had appropriate screening for colorectal cancer.	N/A	Ages 46–49 years, ages 50–75 years, and total ages
UHSU	Developmental Screening in the First Three Years of Life	✓	Measure is calculated by the MCO and validated by IPRO	This 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.	Rate 1: On or before the first birthday. Rate 2: On or before the second birthday. Rate 3: On or before the third birthday.	From birth through 1 year of age, 1–2 years, 2–3 years, and total ages

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Immunizations for Adolescents	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (TDaP) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	The measure calculates a rate for each vaccine and two combination rates. Combination 1 includes the meningococcal and TDaP vaccine, and Combination 2 includes all three vaccinations.	13 years of age
NCQA	Lead Screening in Children	✓	Reported as HEDIS-audited measure	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.	N/A	2 years of age
NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 3–17 years, who had an outpatient visit with a primary care physician or obstetrician/gynecologist (ob/gyn), and who had evidence of weight assessment and counseling. Because body mass index (BMI) norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	Rate 1: BMI percentile documentation. Rate 2: Counseling for nutrition. Rate 3: Counseling for physical activity.	Ages 3–11 years, ages 12–17 years, and total ages

NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable; OHSU: Oregon Health and Science University.

Strengths are identified for MY 2022 Prevention and Screening performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Childhood Immunization Status - Influenza - 9.1 percentage points
  - Childhood Immunization Status - Combo 10 - 8.9 percentage points
  - Chlamydia Screening in Women (Ages 16 to 20 years) - 10.4 percentage points
  - Chlamydia Screening in Women (Ages 21 to 24 years) - 8.3 percentage points
  - Chlamydia Screening in Women (Total) - 9.4 percentage points
  - Developmental Screening in the First Three Years of Life - On or Before First Birthday - 4.1 percentage points
  - Immunizations for Adolescents - HPV - 4.9 percentage points
  - Immunizations for Adolescents - Combination 2 - 4.6 percentage points

Opportunities for improvement are identified for MY 2022 Prevention and Screening performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Colorectal Cancer Screening (Ages 50 to 75 years) - 5.7 percentage points
  - Colorectal Cancer Screening (Total) - 5.1 percentage points

Table 21: Prevention and Screening Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Breast Cancer Screening	17,596	9,398	53.4%	52.7%	54.1%	49.6%	+	55.1%	–	≥ 50th and < 75th percentile
Cervical Cancer Screening	376	209	55.6%	50.4%	60.7%	65.7%	–	58.4%	n.s.	≥ 25th and < 50th percentile
Childhood Immunization Status - Pneumococcal Conjugate	411	304	74.0%	69.6%	78.3%	78.4%	n.s.	75.4%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - DTaP	411	301	73.2%	68.8%	77.6%	75.4%	n.s.	73.3%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - HiB	411	356	86.6%	83.2%	90.0%	88.8%	n.s.	86.3%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - Hepatitis A	411	340	82.7%	79.0%	86.5%	83.7%	n.s.	83.5%	n.s.	≥ 50th and < 75th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Childhood Immunization Status - Hepatitis B	411	355	86.4%	82.9%	89.8%	91.7%	–	89.3%	n.s.	≥ 25th and < 50th percentile
Childhood Immunization Status - IPV	411	355	86.4%	82.9%	89.8%	89.8%	n.s.	87.7%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - Influenza	411	225	54.7%	49.8%	59.7%	55.7%	n.s.	45.6%	+	≥ 90th percentile
Childhood Immunization Status - MMR	411	353	85.9%	82.4%	89.4%	85.9%	n.s.	86.8%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - Rotavirus	411	301	73.2%	68.8%	77.6%	77.1%	n.s.	71.5%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - VZV	411	355	86.4%	82.9%	89.8%	85.9%	n.s.	86.5%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - Combo 3	411	283	68.9%	64.3%	73.5%	71.3%	n.s.	68.0%	n.s.	≥ 75th and < 90th percentile
Childhood Immunization Status - Combo 7	411	255	62.0%	57.2%	66.9%	62.3%	n.s.	59.1%	n.s.	≥ 75th and < 90th percentile
Childhood Immunization Status - Combo 10	411	186	45.3%	40.3%	50.2%	45.7%	n.s.	36.4%	+	≥ 90th percentile
Chlamydia Screening in Women (Ages 16 to 20 years)	10,975	7,011	63.9%	63.0%	64.8%	62.9%	n.s.	53.4%	+	≥ 75th and < 90th percentile
Chlamydia Screening in Women (Ages 21 to 24 years)	9,440	6,598	69.9%	69.0%	70.8%	69.4%	n.s.	61.6%	+	≥ 75th and < 90th percentile
Chlamydia Screening in Women (Total)	20,415	13,609	66.7%	66.0%	67.3%	65.9%	n.s.	57.3%	+	≥ 75th and < 90th percentile
Colorectal Cancer Screening (Ages 50 to 75 years)	41,667	15,799	37.9%	37.5%	38.4%	N/A	N/A	43.6%	–	NA
Colorectal Cancer Screening (Ages 46 to 49 years)	11,312	2,128	18.8%	18.1%	19.5%	N/A	N/A	21.3%	–	NA
Colorectal Cancer Screening (Total)	52,979	17,927	33.8%	33.4%	34.2%	N/A	N/A	39.0%	–	NA
Developmental Screening in the First Three Years of Life - On or Before First Birthday	8,520	5,431	63.7%	62.7%	64.8%	59.8%	+	59.7%	+	NA
Developmental Screening in the First Three Years of Life - On or Before Second Birthday	10,792	6,998	64.8%	63.9%	65.7%	62.4%	+	62.9%	+	NA
Developmental Screening in the First Three Years of Life - On or Before Third Birthday	11,332	7,381	65.1%	64.3%	66.0%	60.6%	+	63.1%	+	NA
Developmental Screening in the First Three Years of Life - Total	30,644	19,810	64.6%	64.1%	65.2%	61.0%	+	62.0%	+	NA
Immunizations for Adolescents - HPV	10,773	4,899	45.5%	44.5%	46.4%	40.5%	+	40.5%	+	≥ 75th and < 90th percentile
Immunizations for Adolescents - Meningococcal	10,773	9,350	86.8%	86.1%	87.4%	84.9%	+	87.9%	–	≥ 75th and < 90th percentile
Immunizations for Adolescents - TDaP	10,773	9,417	87.4%	86.8%	88.0%	85.4%	+	88.2%	n.s.	≥ 50th and < 75th percentile
Immunizations for Adolescents - Combination 1	10,773	9,256	85.9%	85.3%	86.6%	83.7%	+	87.0%	–	≥ 75th and < 90th percentile
Immunizations for Adolescents - Combination 2	10,773	4,809	44.6%	43.7%	45.6%	39.5%	+	40.0%	+	≥ 75th and < 90th percentile
Lead Screening in Children	10,747	8,790	81.8%	81.1%	82.5%	80.9%	n.s.	81.9%	n.s.	≥ 90th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Ages 3 to 11 years)	205	175	85.4%	80.3%	90.5%	82.7%	n.s.	83.6%	n.s.	≥ 50th and < 75th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Ages 12 to 17 years)	116	100	86.2%	79.5%	92.9%	80.7%	n.s.	80.8%	n.s.	≥ 75th and < 90th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	321	275	85.7%	81.7%	89.7%	81.9%	n.s.	82.5%	n.s.	≥ 75th and < 90th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Ages 3 to 11 years)	205	156	76.1%	70.0%	82.2%	76.6%	n.s.	75.7%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Ages 12 to 17 years)	116	79	68.1%	59.2%	77.0%	77.1%	n.s.	71.5%	n.s.	≥ 25th and < 50th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	321	235	73.2%	68.2%	78.2%	76.8%	n.s.	74.1%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Ages 3 to 11 years)	205	143	69.8%	63.2%	76.3%	72.7%	n.s.	70.3%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Ages 12 to 17 years)	116	84	72.4%	63.8%	81.0%	77.1%	n.s.	72.2%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	321	227	70.7%	65.6%	75.9%	74.4%	n.s.	70.9%	n.s.	≥ 50th and < 75th percentile

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "−," and no statistically significant change by "n.s."
[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "−" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Respiratory Conditions

The measures in the Respiratory Conditions category are listed in **Table 22**, followed by the measure data in **Table 23**.

Table 22: Respiratory Conditions Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Appropriate Testing for Pharyngitis	-	Reported as HEDIS-audited measure	This measure assesses the percentage of episodes for members 3 years of age 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).	N/A	Ages 3−17 years, ages 18−64 years, 65 years of age and older, and total ages
NCQA	Asthma Medication Ratio	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 5−64 years 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 MY.	N/A	Ages 5−11 years, ages 12−18 years, ages 19−50 years, ages 51−64 years, and total ages

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	-	Reported as HEDIS-audited measure	This measure assesses the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit on or between January 1 and November 30 of the MY and who were dispensed appropriate medications. The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.	Rate 1: Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. Rate 2: Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.	40 years of age and older
NCQA	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	-	Reported as HEDIS-audited measure	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.	N/A	40 years of age and older

NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable.

Strengths are identified for MY 2022 Respiratory Conditions performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Appropriate Testing for Pharyngitis (Ages 3 to 17 years) - 6.3 percentage points

Opportunities for improvement are identified for MY 2022 Respiratory Conditions performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Appropriate Testing for Pharyngitis (Ages 18 to 64 years) - 14.5 percentage points
  - Appropriate Testing for Pharyngitis (Total) - 5.1 percentage points
  - Asthma Medication Ratio (Ages 5 to 11 years) - 5.3 percentage points
  - Asthma Medication Ratio (Ages 51 to 64 years) - 5.1 percentage points

Table 23: Respiratory Conditions Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Appropriate Testing for Pharyngitis (Ages 3 to 17 years)	2,610	2,140	82.0%	80.5%	83.5%	72.9%	+	75.7%	+	≥ 50th and < 75th percentile
Appropriate Testing for Pharyngitis (Ages 18 to 64 years)	2,562	998	39.0%	37.0%	40.9%	36.9%	n.s.	53.4%	–	< 10th percentile
Appropriate Testing for Pharyngitis (Ages 65 years and older)	19	0	N/A	N/A	N/A	6.7%	N/A	33.3%	N/A	NA
Appropriate Testing for Pharyngitis (Total)	5,191	3,138	60.5%	59.1%	61.8%	51.4%	+	65.5%	–	≥ 10th and < 25th percentile
Asthma Medication Ratio (Ages 5 to 11 years)	2,261	1,595	70.5%	68.6%	72.4%	75.5%	–	75.8%	–	≥ 25th and < 50th percentile
Asthma Medication Ratio (Ages 12 to 18 years)	2,117	1,515	71.6%	69.6%	73.5%	74.4%	–	72.9%	n.s.	≥ 50th and < 75th percentile
Asthma Medication Ratio (Ages 19 to 50 years)	3,842	2,256	58.7%	57.2%	60.3%	59.1%	n.s.	61.2%	–	≥ 25th and < 50th percentile
Asthma Medication Ratio (Ages 51 to 64 years)	1,335	767	57.5%	54.8%	60.1%	58.1%	n.s.	62.6%	–	≥ 25th and < 50th percentile
Asthma Medication Ratio (Total)	9,555	6,133	64.2%	63.2%	65.2%	66.6%	–	66.3%	–	≥ 25th and < 50th percentile
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation - Bronchodilator	941	846	89.9%	87.9%	91.9%	88.3%	n.s.	88.3%	n.s.	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation - Systemic Corticosteroid	941	713	75.8%	73.0%	78.6%	73.0%	n.s.	78.3%	n.s.	≥ 50th and < 75th percentile
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	1,054	239	22.7%	20.1%	25.3%	20.6%	n.s.	23.4%	n.s.	≥ 50th and < 75th percentile

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30; NA: not available, measure does not have HEDIS percentiles to compare.

Utilization

The measures in the Utilization category are listed in **Table 24**, followed by the measure data in **Table 25** and **Table 26**.

Table 24: Utilization Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Ambulatory Care	✓	Reported as HEDIS-audited measure	This measure summarizes utilization of ambulatory care in two categories: outpatient visits, including telehealth, and emergency department visits. Rates are calculated as a percentage of visit counts by member years. MY 2022 is the first report by PH-MCOs for this measure.	Rate 1: Emergency department visits Rate 2: Outpatient visits	1 year of age and younger, ages 1–9 years, ages 10–19 years, ages 20–44 years, ages 45–64 years, ages 65–74 years, ages 75–84 years, 85 years of age and older, and total ages
NCQA	Antibiotic Utilization for Respiratory Conditions	-	Reported as HEDIS-audited measure	This measure assesses the percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.	N/A	Ages 3 months–17 years, ages 18–64 years, 65 years of age and older, and total ages
PA DHS and AHRQ	Asthma in Children and Younger Adults Admission Rate	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the number of discharges for asthma in Members ages 2–39 years per 100,000 Medicaid member months. A lower rate indicates better performance for this measure. The 2–17 age group is collected as a PAPM, and the 18–39 age group is collected per the CMS specification for the adult core set.	N/A	Ages 2–17 years, ages 18–39 years, and total ages 2–39 years
NCQA	Child and Adolescent Well-Care Visit	-	Reported as HEDIS-audited measure	This measure assesses the percentage of enrolled members ages 3–21 years who had at least one comprehensive well-care visit with a primary care physician or an obstetrician/gynecologist (ob/gyn) during the MY.	N/A	Ages 3–11 years, ages 12–17 years, ages 18–21 years, and total ages
AHRQ	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the number of discharges for chronic obstructive pulmonary disease (COPD) or asthma for Medicaid members 40 years of age and older per 100,000 member months. A lower rate indicates better performance.	N/A	Ages 40–64 years, 65 years of age and older, and 40 years of age and older
AHRQ	Diabetes Short-Term Complications Admission Rate	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries 18 years of age and older. A lower rate indicates better performance.	N/A	Ages 18–64 years and 65 years of age and older

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Frequency of Selected Procedures	-	Reported as HEDIS-audited measure	This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization. Rates are calculated as a percentage of procedure counts by member months. Neither a higher nor lower rate indicates better performance.	Rate 1: Back surgery. Females ages 20–44 years and ages 45–64 years and males ages 20–44 years and ages 45–64 years Rate 2: Bariatric weight loss surgery. Females ages 0–19 years, 20–44 years, and 45–64 years and males ages 0–19 years and 20–44 years. Rate 3: Cholecystectomy laparoscopic. Females ages 15–44 years and 45–64 years and males ages 30–64 years. Rate 4: Cholecystectomy open. Females ages 15–44 years and 45–64 years and males ages 30–64 years. Rate 5: Hysterectomy abdominal. Females ages 15–44 years and ages 45–64 years. Rate 6: Hysterectomy vaginal. Females ages 15–44 years and ages 45–64 years. Rate 7: Lumpectomy. Females ages 15–44 years and ages 45–64 years. Rate 8: Mastectomy. Females ages 15–44 years and ages 45–64 years. Rate 9: Tonsillectomy. Females and males ages 0–9 years and ages 10–19 years.	Age groups vary by the measure stratifications
AHRQ	Heart Failure Admission Rate	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the number of discharges for heart failure in adults 18 years of age and older per 100,000 Medicaid member months. A lower rate indicates better performance.	N/A	Ages 18–64 years, 65 years of age and older, and 18 years of age and older
NCQA	Inpatient Utilization	-	Reported as HEDIS-audited measure	This measure summarizes utilization of acute inpatient care and services. Data are reported for the index hospital stays as: average length of stay, days per 1,000 member years, and discharges per 1,000 member years.	Rate 1: Maternity. Age cohorts: ages 10–19 years, 20–44 years, 45–64 years, and total age groups Rate 2: Surgery. Age cohorts: ages 1–9 years, 10–19 years, 20–44 years, 45–64 years, and total age groups Rate 3: Medicine. Age cohorts: ages 1–9 years, 10–19 years, 20–44 years, 45–64 years, and total age groups Rate 4: Total inpatient (the sum of maternity, surgery and medicine). Age cohorts: ages 1–9 years, 10–19 years, 20–44 years, 45–64 years, and total age groups	Age groups vary by the measure stratifications
NCQA	Well-Child Visits in the First 30 Months of Life	✓	Reported as HEDIS audited measure	This measure assesses the percentage of members who turned 30 months old during the MY and who were continuously enrolled from 31 days of age through 30 months of age.	Rate 1: Received six or more well-child visits with a primary care physician during their first 15 months of life. Rate 2: Received two or more well-child visits for ages 15–30 months of life.	30 months of age
NCQA	Plan All-Cause Readmissions	✓	Reported as HEDIS-audited measure	The measure assesses, for members ages 18–64 years, the number of acute inpatient and observation stays during the MY 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. 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.	N/A	Ages 18–44 years, ages 45–54 years, ages 55–64 years, and total ages

NCQA: National Committee for Quality Assurance; AHRQ: Agency for Healthcare Research & Quality; PA DHS: Pennsylvania Department of Human Services; CMS: Centers for Medicare and Medicaid Services; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; N/A: not applicable

Strengths are identified for MY 2022 Utilization performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Asthma in Younger Adults Admission Rate (Age 18 to 39 years) per 100,000 member months – 41.9 Admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months – 62.4 Admissions per 100,000 member months
  - Diabetes Short-Term Complications Admission Rate (Age 65 years and older) per 100,000 member months – 10.3 Admissions per 100,000 member months
  - Heart Failure Admission Rate (Age 65 years and older) per 100,000 member months – 114.6 Admissions per 100,000 member months

Opportunities for improvement are identified for MY 2022 Utilization performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages less than 1 year) - 66.3 Visits per 1000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 1 to 9 years) - 40.1 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 10 to 19 years) - 63.4 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 20 to 44 years) - 51.2 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 45 to 64 years) - 51.4 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 65 to 74 years) - 193.7 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 75 to 84 years) - 398.1 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 85 years and older) - 408.3 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Total) - 61.6 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages less than 1 year) - 1579.1 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 1 to 9 years) - 934.2 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 10 to 19 years) - 652.6 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 20 to 44 years) - 701.9 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 45 to 64 years) - 981.2 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 65 to 74 years) - 4176.7 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 75 to 84 years) - 5758.5 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 85 years and older) - 6949.0 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Total) - 911.8 Visits per 1,000 member years
  - Antibiotic Utilization for Respiratory Conditions (Ages 3 months to 17 years) - 6.2 percentage points
  - Antibiotic Utilization for Respiratory Conditions (Ages 18 to 64 years) - 4.8 percentage points
  - Antibiotic Utilization for Respiratory Conditions (Ages 65 years and older) - 4.9 percentage points
  - Antibiotic Utilization for Respiratory Conditions (Total) - 5.6 percentage points
  - Asthma in Younger Adults Admission Rate (Age 2 to 17 years) per 100,000 member months – 13.3 Admissions per 100,000 member months
  - Asthma in Younger Adults Admission Rate (Total Age 2 to 39 years) per 100,000 member months – 9.4 Admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years) per 100,000 member months – 12.2 Admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 years and older) per 100,000 member months – 8.7 Admissions per 100,000 member months
  - Heart Failure Admission Rate (Ages 18 to 64 years) per 100,000 member months – 4.5 Admissions per 100,000 member months
  - Well-Child Visits in the First 30 Months of Life (First 15 Months) - 3.9 percentage points
  - Well-Child Visits in the First 30 Months of Life (15 Months to 30 Months) - 3.0 percentage points

Table 25: Utilization Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages less than 1 year)[3]	133,854	11,353	1017.8	N/A	N/A	876.6	+	1084.1	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 1 to 9 years)[3]	1,282,860	53,172	497.4	N/A	N/A	420.8	+	537.4	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 10 to 19 years)[3]	1,333,128	38,124	343.2	N/A	N/A	341.8	+	406.6	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 20 to 44 years)[3]	1,953,787	111,293	683.6	N/A	N/A	768.1	–	734.8	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 45 to 64 years)[3]	857,806	44,680	625.0	N/A	N/A	636.4	–	676.5	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 65 to 74 years)[3]	32,189	1,016	378.8	N/A	N/A	402.0	–	572.5	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 75 to 84 years)[3]	10,812	183	203.1	N/A	N/A	197.0	+	601.2	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 85 years and older)[3]	2,969	36	145.5	N/A	N/A	190.9	–	553.8	–	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Total)[3]	5,607,405	259,857	556.1	N/A	N/A	563.4	–	617.7	–	≥ 25th and < 50th percentile
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages unknown)[3]	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages less than 1 year)[3]	133,854	83,780	7510.9	N/A	N/A	7324.7	+	9090.0	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 1 to 9 years)[3]	1,282,860	266,643	2494.2	N/A	N/A	2288.9	+	3428.4	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 10 to 19 years)[3]	1,333,128	240,723	2166.8	N/A	N/A	2206.1	–	2819.5	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 20 to 44 years)[3]	1,953,787	475,828	2922.5	N/A	N/A	3209.4	–	3624.4	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 45 to 64 years)[3]	857,806	374,169	5234.3	N/A	N/A	5464.9	–	6215.5	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 65 to 74 years)[3]	32,189	14,253	5313.5	N/A	N/A	5392.9	–	9490.2	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 75 to 84 years)[3]	10,812	4,064	4510.5	N/A	N/A	4927.3	–	10269.0	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 85 years and older)[3]	2,969	851	3439.5	N/A	N/A	3574.0	–	10388.6	–	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Total)[3]	5,607,405	1,460,311	3125.1	N/A	N/A	3211.9	–	4036.9	–	≥ 10th and < 25th percentile
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages unknown)[3]	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
Antibiotic Utilization for Respiratory Conditions (Ages 3 months to 17 years)	136,428	17,206	12.6%	12.4%	12.8%	N/A	N/A	18.8%	–	NA
Antibiotic Utilization for Respiratory Conditions (Ages 18 to 64 years)	105,616	12,013	11.4%	11.2%	11.6%	N/A	N/A	16.2%	–	NA
Antibiotic Utilization for Respiratory Conditions (Ages 65 years and older)	1,234	114	9.2%	7.6%	10.9%	N/A	N/A	14.1%	–	NA
Antibiotic Utilization for Respiratory Conditions (Total)	243,278	29,333	12.1%	11.9%	12.2%	N/A	N/A	17.6%	–	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Asthma in Younger Adults Admission Rate (Age 2 to 17 years) per 100,000 member months	2,239,556	646	28.8	N/A	N/A	18.4	+	15.5	+	NA
Asthma in Younger Adults Admission Rate (Age 18 to 39 years) per 100,000 member months	1,889,259	170	9.0	N/A	N/A	91.9	–	50.9	+	NA
Asthma in Younger Adults Admission Rate (Total Age 2 to 39 years) per 100,000 member months	4,128,815	816	19.8	N/A	N/A	14.3	+	10.4	+	NA
Child and Adolescent Well-Care Visits (Ages 3 to 11 years)	99,089	65,797	66.4%	66.1%	66.7%	67.6%	–	66.3%	n.s.	≥ 75th and < 90th percentile
Child and Adolescent Well-Care Visits (Ages 12 to 17 years)	64,010	38,806	60.6%	60.2%	61.0%	62.7%	–	59.9%	+	≥ 75th and < 90th percentile
Child and Adolescent Well-Care Visits (Ages 18 to 21 years)	34,145	12,592	36.9%	36.4%	37.4%	38.2%	–	35.9%	+	≥ 75th and < 90th percentile
Child and Adolescent Well-Care Visits (Total)	197,244	117,195	59.4%	59.2%	59.6%	61.1%	–	58.9%	+	≥ 75th and < 90th percentile
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years) per 100,000 member months	1,157,806	526	45.4	N/A	N/A	55.0	–	33.2	+	NA
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months	46,063	11	23.9	N/A	N/A	40.9	–	86.3	–	NA
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 years and older) per 100,000 member months	1,203,869	537	44.6	N/A	N/A	54.5	–	35.9	+	NA
Diabetes Short-Term Complications Admission Rate (Ages 18-64 years) per 100,000 member months	3,047,065	579	19.0	N/A	N/A	22.5	–	16.3	+	NA
Diabetes Short-Term Complications Admission Rate (Age 65 years and older) per 100,000 member months	46,063	0	0.0	0.0	0.0	15.3	–	10.3	–	NA
Diabetes Short-Term Complications Admission Rate (Age 18 years and older) per 100,000 member months	3,093,128	579	18.7	N/A	N/A	22.4	–	16.2	+	NA
Frequency of Selected Procedures - Back Surgery (Females ages 20 to 44 years)	1,172,504	90	0.9	0.9	0.9	1.0	–	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Back Surgery (Females ages 45 to 64 years)	454,726	123	3.3	3.2	3.3	2.9	+	N/A	N/A	≥ 10th and < 25th percentile
Frequency of Selected Procedures - Back Surgery (Males ages 20 to 44 years)	781,283	69	1.1	1.0	1.1	1.2	–	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Back Surgery (Males ages 45 to 64 years)	403,080	130	3.9	3.8	3.9	4.8	–	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 0 to 19 years)	1,335,103	20	0.2	0.2	0.2	0.0	+	N/A	N/A	≥ 90th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 20 to 44 years)	1,172,504	311	3.2	3.1	3.2	3.5	–	N/A	N/A	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 45 to 64 years)	454,726	73	1.9	1.9	2.0	2.4	–	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 0 ages 19 years)	1,414,739	4	0.0	0.0	0.0	0.0	+	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 20 and 44 years)	781,283	29	0.5	0.4	0.5	0.4	+	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 45 to 64 years)	403,080	19	0.6	0.5	0.6	0.6	–	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 15 to 44 years)	1,480,690	395	3.2	3.2	3.2	3.6	–	N/A	N/A	≥ 10th and < 25th percentile
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 45 to 64 years)	454,726	134	3.5	3.5	3.6	3.5	+	N/A	N/A	≥ 10th and < 25th percentile
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Males ages 30 to 64 years)	829,001	84	1.2	1.2	1.2	1.2	+	N/A	N/A	< 10th percentile
Frequency of Selected Procedures - Cholecystectomy Open (Females ages 15 to 44 years)	1,480,690	13	0.1	0.1	0.1	0.1	–	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Cholecystectomy Open (Females ages 45 to 64 years)	454,726	3	0.1	0.1	0.1	0.4	–	N/A	N/A	≥ 10th and < 25th percentile
Frequency of Selected Procedures - Cholecystectomy Open (Males ages 30 to 64 years)	829,001	18	0.3	0.2	0.3	0.4	–	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 15 to 44 years)	1,480,690	82	0.7	0.6	0.7	0.8	–	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 45 to 64 years)	454,726	76	2.0	2.0	2.1	1.4	+	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 15 to 44 years)	1,480,690	45	0.4	0.4	0.4	0.4	n.s.	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 45 to 64 years)	454,726	43	1.1	1.1	1.2	1.0	+	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Lumpectomy (Females ages 15 to 44 years)	1,480,690	132	1.1	1.1	1.1	1.2	–	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Lumpectomy (Females ages 45 to 64 years)	454,726	142	3.8	3.7	3.8	3.4	+	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Mastectomy (Females ages 15 to 44 years)	1,480,690	180	1.5	1.4	1.5	1.2	+	N/A	N/A	≥ 90th percentile
Frequency of Selected Procedures - Mastectomy (Females ages 45 to 64 years)	454,726	70	1.9	1.8	1.9	2.4	–	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Tonsillectomy (Males and Females ages 0 to 9 years)	1,416,714	467	4.0	3.9	4.0	2.6	+	N/A	N/A	≥ 25th and < 50th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Frequency of Selected Procedures - Tonsillectomy (Males and Females ages 10 to 19 years)	1,333,128	154	1.4	1.4	1.4	1.2	+	N/A	N/A	≥ 25th and < 50th percentile
Heart Failure Admission Rate (Ages 18 to 64 years) per 100,000 member months	3,047,065	744	24.4	N/A	N/A	29.0	–	19.9	+	NA
Heart Failure Admission Rate (Age 65 years and older) per 100,000 member months	46,063	27	58.6	N/A	N/A	66.4	–	173.2	–	NA
Heart Failure Admission Rate (Age 18 years and older) per 100,000 member months	3,093,128	771	24.9	N/A	N/A	29.5	–	23.0	+	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	618	1,687	2.7	1.4	4.1	31.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	8,017	22,536	2.8	2.4	3.2	32.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	36	172	4.8	-3.6	13.1	53.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Total)[3]	8,671	24,395	2.8	2.5	3.2	32.6	N/A	N/A	N/A	≥ 75th and < 90th percentile
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	1,687	15.2	15.1	15.3	16.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	22,536	138.4	N/A	N/A	147.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	172	2.4	2.4	2.4	1.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Total)[3]	4,144,721	24,395	70.6	70.6	70.7	74.0	N/A	N/A	N/A	≥ 50th and < 75th percentile
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	618	5.6	5.5	5.6	6.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	8,017	49.2	49.2	49.3	54.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	36	0.5	0.5	0.5	0.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Total)[3]	4,144,721	8,671	25.1	25.1	25.1	27.2	N/A	N/A	N/A	≥ 50th and < 75th percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages less than 1 year)[3]	1,294	7,551	5.8	4.5	7.2	78.4	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 1 to 9 years)[3]	2,360	8,045	3.4	2.7	4.2	42.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	1,536	7,561	4.9	3.8	6.0	53.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	6,757	26,687	4.0	3.5	4.4	43.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	7,524	34,126	4.5	4.1	5.0	53.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 65 to 74 years)[3]	234	1,023	4.4	1.5	7.2	61.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 75 to 84 years)[3]	63	325	5.2	-1.1	11.4	54.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 85 years and older)[3]	29	112	3.9	N/A	N/A	69.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Total)[3]	19,797	85,430	4.3	4.0	4.6	49.9	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages less than 1 year)[3]	133,854	7,551	677.0	N/A	N/A	587.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 1 to 9 years)[3]	1,282,860	8,045	75.3	75.2	75.3	60.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	7,561	68.1	68.0	68.1	60.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	26,687	163.9	N/A	N/A	177.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	34,126	477.4	N/A	N/A	553.9	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 65 to 74 years)[3]	32,189	1,023	381.4	N/A	N/A	493.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 75 to 84 years)[3]	10,812	325	360.7	N/A	N/A	454.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 85 years and older)[3]	2,969	112	452.7	N/A	N/A	609.8	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Total)[33]	5,607,405	85,430	182.8	N/A	N/A	191.4	N/A	N/A	N/A	≥ 75th and < 90th percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages less than 1 year)	133,854	1,294	116.0	N/A	N/A	90.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 1 to 9 years)[3]	1,282,860	2,360	22.1	22.0	22.2	17.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	1,536	13.8	13.8	13.9	13.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	6,757	41.5	41.4	41.6	49.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	7,524	105.3	N/A	N/A	125.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 65 to 74 years)[3]	32,189	234	87.2	86.9	87.6	97.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 75 to 84 years)[3]	10,812	63	69.9	69.1	70.8	99.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 85 years and older)[3]	2,969	29	117.2	N/A	N/A	106.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Total)[3]	5,607,405	19,797	42.4	42.3	42.4	46.1	N/A	N/A	N/A	≥ 75th and < 90th percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages less than 1 year)[3]	211	5,434	25.8	19.6	31.9	334.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 1 to 9 years)[3]	413	5,865	14.2	10.7	17.7	130.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	528	5,118	9.7	7.1	12.3	103.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	2,830	20,128	7.1	6.1	8.1	82.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	2,973	23,133	7.8	6.8	8.8	90.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 65 to 74 years)[3]	84	646	7.7	1.4	14.0	77.6	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 75 to 84 years)[3]	23	247	10.7	N/A	N/A	77.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 85 years and older)[3]	7	36	5.1	N/A	N/A	86.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Total)[3]	7,069	60,607	8.6	7.9	9.2	97.3	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages less than 1 year)[3]	133,854	5,434	487.2	N/A	N/A	586.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 1 to 9 years)[3]	1,282,860	5,865	54.9	54.8	54.9	38.5	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	5,118	46.1	46.0	46.2	46.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	20,128	123.6	N/A	N/A	136.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	23,133	323.6	N/A	N/A	378.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 65 to 74 years)[3]	32,189	646	240.8	N/A	N/A	330.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 75 to 84 years)[3]	10,812	247	274.1	N/A	N/A	267.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 85 years and older)[3]	2,969	36	145.5	N/A	N/A	228.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Total)[3]	5,607,405	60,607	129.7	N/A	N/A	141.1	N/A	N/A	N/A	≥ 50th and < 75th percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages less than 1 year)[3]	133,854	211	18.9	18.7	19.1	21.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 1 to 9 years)[3]	1,282,860	413	3.9	3.8	3.9	3.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	528	4.8	4.7	4.8	5.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	2,830	17.4	17.3	17.4	19.9	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	2,973	41.6	41.5	41.7	50.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 65 to 74 years)[3]	32,189	84	31.3	30.8	31.8	51.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 75 to 84 years)[3]	10,812	23	25.5	24.7	26.4	41.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 85 years and older)[3]	2,969	7	28.3	26.7	29.9	31.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Total)[3]	5,607,405	7,069	15.1	15.1	15.2	17.4	N/A	N/A	N/A	≥ 50th and < 75th percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages less than 1 year)[3]	1,505	12,985	8.6	7.2	10.1	126.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 1 to 9 years)[3]	2,773	13,910	5.0	4.2	5.9	57.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	2,682	14,366	5.4	4.5	6.2	58.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	17,604	69,351	3.9	3.6	4.2	45.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	10,533	57,431	5.5	5.0	5.9	63.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 65 to 74 years)[3]	318	1,669	5.3	2.6	7.9	66.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 75 to 84 years)[3]	86	572	6.7	0.8	12.5	61.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 85 years and older)[3]	36	148	4.1	-3.8	12.0	73.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Total)[3]	35,537	170,432	4.8	4.6	5.0	55.7	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages less than 1 year)[3]	133,854	12,985	1164.1	N/A	N/A	1174.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 1 to 9 years)[3]	1,282,860	13,910	130.1	N/A	N/A	98.6	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	14,366	129.3	N/A	N/A	122.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	69,351	426.0	N/A	N/A	461.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	57,431	803.4	N/A	N/A	933.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years(Ages 65 to 74 years)[3]	32,189	1,669	622.2	N/A	N/A	824.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 75 to 84 years)[3]	10,812	572	634.9	N/A	N/A	722.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 85 years and older)[3]	2,969	148	598.2	N/A	N/A	837.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Total)[3]	5,607,405	170,432	364.7	N/A	N/A	386.6	N/A	N/A	N/A	≥ 50th and < 75th percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages less than 1 year)[3]	133,854	1,505	134.9	N/A	N/A	111.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 1 to 9 years)[3]	1,282,860	2,773	25.9	25.9	26.0	20.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	1,333,128	2,682	24.1	24.1	24.2	25.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,953,787	17,604	108.1	N/A	N/A	123.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	857,806	10,533	147.4	N/A	N/A	175.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 65 to 74 years)[3]	32,189	318	118.6	N/A	N/A	148.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 75 to 84 years)[3]	10,812	86	95.5	95.1	95.8	141.5	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 85 years and older)[3]	2,969	36	145.5	N/A	N/A	137.9	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Total)[3]	5,607,405	35,537	76.1	76.0	76.1	83.3	N/A	N/A	N/A	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Well-Child Visits in the First 30 Months of Life (First 15 Months)	9,372	6,015	64.2%	63.2%	65.2%	57.9%	+	68.1%	–	≥ 75th and < 90th percentile
Well-Child Visits in the First 30 Months of Life (15 Months to 30 Months)	10,941	7,770	71.0%	70.2%	71.9%	69.0%	+	74.0%	–	≥ 50th and < 75th percentile

[1] For comparison of MY 2022 rates to MY 2021 rates, statistically significant increases are indicated by "+," statistically significant decreases by "–," and no statistically significant change by "n.s."
[2] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
[3]HEDIS measures Ambulatory Care and Inpatient Utilization calculations changed from member months in MY 2021 to member years in MY 2022. Per NCQA guidance, MY 2021 rates were multiplied by 12 to trend data to MY 2022.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable or the denominator was less than 30

Table 26: Plan All-Cause Readmission Measure Data

Age Group	Count of Index Hospital Stays (IHS)—Total Stays	Count of Observed 30-Day Readmissions —Total Stays	Observed Readmission Rate - Total Stays[1]	Count of Expected 30-Day Readmissions —Total Stays	Expected Readmission Rate - Total Stays[2]	MY 2022 Observed to Expected Readmission Ratio - Total Stays[3]	MY 2021 Observed to Expected Readmission Ratio - Total Stays[3]
Ages 18 to 44 years	6,085	637	10.5%	517.7	8.5%	1.2	1.2
Ages 45 to 54 years	2,800	328	11.7%	287.7	10.3%	1.1	1.2
Ages 55 to 64 years	3,341	399	11.9%	398.7	11.9%	1.0	1.0
Ages 18 to 64 years	12,226	1,364	11.2%	1,204.0	9.9%	1.1	1.2

[1]The observed readmission rate is calculated by dividing the count of observed 30-day readmissions by the count of index hospital stays.
[2]The expected readmission rate is calculated by dividing the count of expected 30-day readmissions by the count of index hospital stays.
[3]The observed to expected readmission ratio is calculated by dividing the observed readmission rate by the expected readmission rate.

IV. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

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

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

Technical Methods of Data Collection and Analysis

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO's compliance status with regard to the SMART items. For example, all provisions relating to availability of services are summarized under *Title 42 CFR § 438.206 Availability of services*. 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 Compliant or Non-compliant are indicated where applicable in the tables below, and the SMART items that were assigned a value of Non-compliant by DHS within those categories are noted. For KF, there were no categories determined to be Partially Compliant or Non-compliant, signifying that no SMART items were assigned a value of Non-compliant by DHS. There are therefore no recommendations related to compliance with structure and operations standards for KF for the current review year.

Description of Data Obtained

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 CMS's *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations*. Under each subpart heading falls the individual regulatory

categories appropriate to those headings. Findings will be further discussed relative to applicable subparts as indicated in the updated protocol (i.e., Subpart D – MCO, PIHP, and PAHP Standards and Subpart E – Quality Measurement and Improvement). This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the MCO's compliance with BBA regulations as an element of the analysis of the MCO's strengths and weaknesses.

The documents used by IPRO for the current review include the HealthChoices Agreement, the SMART database completed by Pennsylvania DHS staff as of December 31, 2022, additional monitoring activities outlined by DHS staff, and the most recent NCQA Accreditation Survey for KF effective in the review year.

The SMART items provided much of the information necessary for this review. The SMART items and their associated review findings for each year are maintained in a database. The SMART database has been maintained internally at DHS since review year 2013. Beginning in 2018 (review year 2017), there were changes implemented to the review process that impacted the data that are received annually. First, the only available review conclusions are Compliant and Non-compliant. All other options previously available were re-designated from review conclusion elements to review status elements and are therefore not included in the findings. Additionally, as noted, reviewers were given the option to review zones covered by an MCO separately and to provide multiple findings within a year (e.g., quarterly). As a result, there was an increase in the number of Partially Compliant items for the initial year. For use in the current review, IPRO reviewed the data elements from each version of the database and then merged the 2022, 2021, and 2020 findings. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 134 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations.

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

Table 27 provides a count of items linked to each category. Additionally, **Table 27** includes all regulations and standards from the three-year review period (2022, 2021, and 2020), which incorporates both the prior and the most recent set of EQR protocols. The CMS regulations are reflected in **Table 27** as follows: 1) a "Required" column has been included to indicate the 14 standards that CMS has designated as subject to compliance review; and 2) a "Related" column has been included to indicate standards that CMS has deemed as incorporated into the compliance review through interaction with the required standards.

Table 27: SMART Items Count Per Regulation

BBA Regulation	SMART Items	Required	Related
Subpart B: State Responsibilities			
Disenrollment Requirements	1	✓	-
Subpart C: Enrollee Rights and Protections			
Enrollee Rights	7	-	✓
Provider-Enrollee Communication	1	-	✓
Marketing Activities	2	-	✓
Cost Sharing	0	-	-
Emergency and Post-Stabilization Services	5	✓	-
Subpart D: MCO, PIHP, and PAHP Standards			
Availability of Services	14	✓	-
Assurances of Adequate Capacity and Services	3	✓	-
Coordination and Continuity of Care	13	✓	-
Coverage and Authorization of Services	9	✓	-
Provider Selection	4	✓	-
Provider Discrimination Prohibited	1	-	✓
Confidentiality	1	✓	-
Enrollment and Disenrollment	2	-	✓
Grievance and Appeal System	1	✓	-
Subcontractual Relationships and Delegations	3	✓	-
Practice Guidelines	2	✓	-
Health Information Systems	18	✓	-
Subpart E: Quality Measurement and Improvement; External Quality Review			
QAPI Program	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	-	✓

SMART: Systematic Monitoring, Access, and Retrieval Technology; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan; QAPI: Quality Assessment and Performance Improvement.

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

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

Conclusions and Comparative Findings

Of the 134 SMART items, 88 items were evaluated and 47 were not evaluated for the MCO in 2022, 2021, or 2020. For categories where items were not evaluated for compliance for 2022, results from reviews conducted within the two prior years (2021 and 2020) were evaluated to determine compliance, if available. Given that the MCO was found to be non-compliant in the Health Information Systems category, IPRO recommends that particular focus is placed on improving infrastructure and accessibility related to this area going forward.

Subpart B: State Responsibilities

The general purpose of the regulations included in this category is to ensure that each MCO specifies the reason for an enrollee's disenrollment, and that there is no other reason for disenrollment other than what is permitted under contract (*Title 42 CFR § 438.56 (b)*). The SMART database and DHS's audit document information include assessment of the MCO's compliance with regulations found in Subpart B. **Table 28** presents the findings by categories consistent with the regulations.

Table 28: KF Compliance with State Responsibilities

State Responsibilities		
Subpart B: Categories	Compliance	Comments
Disenrollment Requirements	Compliant	One item was crosswalked to this category. The MCO was evaluated against one item and was compliant this item based on review year 2022.

KF was evaluated against the one SMART item crosswalked to State Responsibilities and was compliant on this one item.

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 Members (*Title 42 CFR § 438.100 (a)–(b)*). The SMART database and DHS's audit document information include assessment of the MCO's compliance with regulations found in Subpart C. **Table 29** presents the findings by categories consistent with the regulations.

Table 29: KF Compliance with Enrollee Rights and Protections Regulations

Enrollee Rights and Protections Regulations		
Subpart C: Categories	Compliance	Comments
Enrollee Rights	Compliant	Seven items were crosswalked to this category. The MCO was evaluated against six items and was compliant on six items based on review year 2022.
Provider-Enrollee Communication	Compliant	One item was crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Marketing Activities	Compliant	Two items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Cost Sharing	Compliant	Per HealthChoices Agreement
Emergency and Post-Stabilization Services	Compliant	Five items were crosswalked to this category. The MCO was evaluated against four items and was compliant on four items based on review year 2022.

MCO: managed care organization.

KF was evaluated against 13 of the 15 SMART items crosswalked to Enrollee Rights and Protections regulations and was compliant on all 13 items. KF was found to be compliant on all eight of the categories of Enrollee Rights and Protections regulations. KF 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 KF Members (*Title 42 CFR § 438.206 (a)*). The SMART database includes an assessment of the MCO's compliance with regulations found in Subpart D. For the category of Assurances of Adequate Capacity and Services, the MCO was evaluated as noted above against additional SMART items and DHS monitoring activities. **Table 30** presents the findings by categories consistent with the regulations.

Table 30: KF Compliance with MCO, PIHP, and PAHP Standards Regulations

MCO, PIHP, and PAHP Standards Regulations		
Subpart D: Categories	Compliance	Comments
Availability of Services	Compliant	Fourteen items were crosswalked to this category. The MCO was evaluated against 11 items and was compliant on 11 items based on review year 2022.
Assurances of Adequate Capacity and Services	Compliant	Three items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Coordination and Continuity of Care	Compliant	Thirteen items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on 12 items based on review year 2022.
Coverage and Authorization of Services	Compliant	Nine items were crosswalked to this category. The MCO was evaluated against seven items and was compliant on seven items based on review year 2022.

MCO, PIHP, and PAHP Standards Regulations		
Subpart D: Categories	Compliance	Comments
Provider Selection	Compliant	Four items were crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Provider Discrimination Prohibited	Compliant	One item was crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Confidentiality	Compliant	One item was crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Enrollment and Disenrollment	Compliant	Two items were crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Grievance and Appeal System	Compliant	One item was crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Subcontractual Relationships and Delegations	Compliant	Three items were crosswalked to this category. The MCO was evaluated against three items and was compliant on three items based on review year 2022.
Practice Guidelines	Compliant	Two items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Health Information Systems	Partially Compliant	Eighteen items were crosswalked to this category. The MCO was evaluated against 11 items and was compliant on 10 items and non-compliant on one item based on review year 2022.

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

KF was evaluated against 53 of 71 SMART items that were crosswalked to MCO, PIHP, and PAHP Standards regulations and was compliant on 52 items and non-compliant on one of the Health Information Systems items. Of the 12 categories in MCO, PIHP, and PAHP Standards, KF was found to be compliant on 10 categories and partially compliant on one category, Health Information Systems.

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 Quality Assessment and Performance Improvement Program for the services it furnishes to its Medicaid Members (*Title 42 CFR § 438.330*). The MCO's compliance with the regulation found in Subpart E was evaluated as noted above against additional SMART items and DHS monitoring activities. **Table 31** presents the findings by categories consistent with the regulation.

Table 31: KF Compliance with Quality Measurement and Improvement; EQR Regulations

Quality Measurement and Improvement; EQR Regulations		
Subpart E: Categories	Compliance	Comments
Quality Assessment and Performance Improvement Program	Compliant	Nine items were crosswalked to this category. The MCO was evaluated against nine items and was compliant on nine items based on review year 2022.

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

KF was evaluated against nine of the nine SMART items crosswalked to Quality Assessment and Performance Improvement Program and was compliant on the nine items.

Subpart F: Grievance and Appeal System

The general purpose of the regulations included under this heading is to ensure that Members 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 32** presents the findings by categories consistent with the regulations.

Table 32: KF Compliance with Grievance and Appeal System Regulations

Grievance and Appeal System Regulations		
Subpart F: Categories	Compliance	Comments
General Requirements	Compliant	Eight items were crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Notice of Action	Compliant	Three items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Handling of Grievances & Appeals	Compliant	Nine items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Resolution and Notification	Compliant	Seven items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Expedited Resolution	Compliant	Four items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Information to Providers and Subcontractors	Compliant	One item was crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Recordkeeping and Recording	Compliant	Six items were crosswalked to this category. The MCO was evaluated against two items and was compliant on two items based on review year 2022.
Continuation of Benefits Pending Appeal and State Fair Hearings	Compliant	Two items were crosswalked to this category. The MCO was evaluated against one item and was compliant on this item based on review year 2022.
Effectuation of Reversed Resolutions	Compliant	Per NCQA Accreditation, 2023. (See "Accreditation Status" subsection.)

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

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

Accreditation Status

KF underwent an NCQA Accreditation Survey evaluation June 30, 2023, due to the ongoing COVID-19 pandemic. The evaluation is effective through September 26, 2023. They were granted an Accreditation Status of Accredited.

V. Validation of Network Adequacy

Objectives

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

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, Pennsylvania contracted with IPRO to perform the validation of network adequacy for Pennsylvania MCOs. In February 2023, CMS released updates to the EQR protocols, including the newly developed network adequacy validation protocol. The six protocol activities related to planning, analysis, and reporting are outlined in **Table 33**.

Table 33: Network Adequacy Validation Activities

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

[1] At the time of this report, only activities 1 and 2 were conducted for measurement year 2022.

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

Technical Methods of Data Collection and Analysis

IPRO gathered information from Pennsylvania to conduct preliminary network adequacy validation activities using worksheets 4.1, 4.2, and 4.3 of the 2023 CMS EQR protocols. The worksheets identified clear definitions for each network adequacy standard and indicator, including the data sources for validation.

Description of Data Obtained

Network adequacy standards are quantitative parameters that states establish to set expectations for contracted MCOs' provider networks. Network adequacy indicators are metrics used to measure adherence to network adequacy standards and to determine plan compliance with state network adequacy standards. The Pennsylvania-established access, distance, and time standards are presented by the two Pennsylvania geographical regions: urban and rural. **Table 34** displays the Pennsylvania physical health provider network standards that were applicable in MY 2022.

Table 34: Network Adequacy Standards, Indicators, and Data Sources

Pennsylvania Network Access Standards	Applicable Provider Types	Network Adequacy Indicator	Definition of Network Adequacy Indicator	Network Adequacy Indicator Data Source
Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban). This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.	Primary Care Providers	Proportion of beneficiaries who have a primary care provider accepting new Medicaid patients within 30 minutes from their address.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than sixty (60) minutes (Rural). This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.	Primary Care Providers	Proportion of beneficiaries who have a primary care provider accepting new Medicaid patients within 60 minutes from their address.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within 30 minutes (urban).	Pediatricians as Primary Care Providers	Proportion of appropriate beneficiaries who have a pediatrician accepting new Medicaid patients within 30 minutes from their address.	Numerator: Number of pediatric members meeting the indicator. Denominator: Total pediatric members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within 60 minutes (rural).	Pediatricians as Primary Care Providers	Proportion of appropriate beneficiaries who have a pediatrician accepting new Medicaid patients within 60 minutes from their address.	Numerator: Number of pediatric members meeting the indicator. Denominator: Total pediatric members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure a choice of two (2) providers who are accepting new patients within 30 minutes (urban).	General Surgery, Cardiology, Obstetrics & Gynecology, Pharmacy, Oncology, Orthopedic Surgery, Physical Therapy, General Dentistry, Radiology, Pediatric Dentistry	Proportion of beneficiaries who have a specialist accepting new Medicaid patients within 30 minutes from their address.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure a choice of two (2) providers who are accepting new patients within 60 minutes (rural).	General Surgery, Cardiology, Obstetrics & Gynecology, Pharmacy, Oncology, Orthopedic Surgery, Physical Therapy, General Dentistry, Radiology, Pediatric Dentistry	Proportion of beneficiaries who have a specialist accepting new Medicaid patients within 60 minutes from their address.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure a choice of one (1) provider who is accepting new patients within 30 minutes (urban) and a second choice within the HealthChoices Zone.	Oral Surgery, Urology, Nursing Facility, Neurology, Dermatology, Otolaryngology, Oncology, Radiology, Physical Therapy	Proportion of beneficiaries who have a specialist accepting new Medicaid patients within 30 minutes from their address as well as a second choice within the geographic zone.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure a choice of one (1) provider who is accepting new patients within 60 minutes (rural) and a second choice within the HealthChoices Zone.	Oral Surgery, Urology, Nursing Facility, Neurology, Dermatology, Otolaryngology, Oncology, Radiology, Physical Therapy	Proportion of beneficiaries who have a specialist accepting new Medicaid patients within 60 minutes from their address as well as a second choice within the geographic zone.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
The PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.	All other specialists and subspecialists not previously identified.	Number of beneficiaries within the geographic zone (if the MCO does not have the necessary number of providers within the zone, then their network would be inadequate for every member in the zone)	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)

Pennsylvania Network Access Standards	Applicable Provider Types	Network Adequacy Indicator	Definition of Network Adequacy Indicator	Network Adequacy Indicator Data Source
Ensure at least one (1) hospital within 60 minutes (rural) and a second choice within the HealthChoices Zone.	Hospitals	Proportion of appropriate beneficiaries who have an in-network hospital within 60 minutes from their address as well as second choice within the geographic zone	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure at least one (1) hospital within 30 minutes (urban) and a second choice within the HealthChoices Zone.	Hospitals	Proportion of appropriate beneficiaries who have an in-network hospital within 30 minutes from their address as well as second choice within the geographic zone	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure at least two (2) specialists or subspecialists qualified to meet the particular needs of persons who have special health needs or who face access barriers to health care within 30 minutes (urban). (If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services.)	Specialists or sub-specialists qualified to meet the needs of persons who have special needs or who face access barriers to healthcare.	Proportion of beneficiaries who have a qualified specialist accepting new Medicaid patients within 30 minutes from their address.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure at least two (2) specialists or subspecialists qualified to meet the particular needs of persons who have special health needs or who face access barriers to health care within 60 minutes (rural). (If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services.)	Specialists or sub-specialists qualified to meet the needs of persons who have special needs or who face access barriers to healthcare.	Proportion of beneficiaries who have a qualified specialist accepting new Medicaid patients within 60 minutes from their address.	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure at least two (2) specialists or subspecialists qualified to meet the particular needs of children who have special health needs or who face access barriers to health care within 30 minutes (urban). (If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services.)	Pediatric specialists or pediatric sub-specialists qualified to meet the needs of children who have special needs or who face access barriers to healthcare.	Proportion of beneficiaries who have a qualified specialist accepting new Medicaid patients within 30 minutes from their address.	Numerator: Number of pediatric members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure at least two (2) specialists or subspecialists qualified to meet the particular needs of children who have special health needs or who face access barriers to health care within 60 minutes (rural). (If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services.)	Pediatric specialists or pediatric sub-specialists qualified to meet the needs of persons who have special needs or who face access barriers to healthcare.	Proportion of beneficiaries who have a qualified specialist accepting new Medicaid patients within 60 minutes from their address.	Numerator: Number of pediatric members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
The PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.	Dentists with privileges or certificates to perform specialized dental procedures under general anesthesia.	Number of beneficiaries within the geographic zone (if the MCO does not have the necessary number of providers within the zone, then their network would be inadequate for every member in the zone or they would have to allow the member to go out of network)	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)

Pennsylvania Network Access Standards	Applicable Provider Types	Network Adequacy Indicator	Definition of Network Adequacy Indicator	Network Adequacy Indicator Data Source
Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.	Rehabilitation facilities	Number of beneficiaries within the geographic zone (if the MCO does not have the necessary number of facilities within the zone, then their network would be inadequate for every member in the zone)	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. In accordance with RX for PA Principles, the PH-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.	Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers	Number of beneficiaries within the geographic zone (if the MCO does not have the necessary number of providers within the zone, then their network would be inadequate for every member in the zone)	Numerator: Number of members meeting the indicator. Denominator: Total members enrolled with the MCO in the zone	Provider Network Data Files (Weekly) Provider Network Analysis Report (Annual)
The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following: • No less than seventy-five percent (75) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and • No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.	Primary Care Providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Network Analysis Report (Annual) QM UM Reports (Annual)
At a minimum, the PH-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PHMCO if necessary to maintain the appointment availability standards.	Primary Care Providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	SMART standard i/o 10.2
Consistent with 42 C.F.R. §438.14(b)(1-3), The PH-MCO must demonstrate that there are sufficient Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in the network to ensure timely access to services available under the Agreement for Indian Members who are eligible to receive services from such providers.	I/T/U Providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
The PH-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.	Primary Care Providers, dentists	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual; SMART standard i/o 39.3

Pennsylvania Network Access Standards	Applicable Provider Types	Network Adequacy Indicator	Definition of Network Adequacy Indicator	Network Adequacy Indicator Data Source
PCP scheduling procedures must ensure that emergency Medical Condition cases must be immediately seen or referred to an emergency facility.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
PCP scheduling procedures must ensure that urgent medical condition cases must be scheduled within twenty-four (24) hours.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
PCP scheduling procedures must ensure that routine appointments must be scheduled within ten (10) Business Days.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
PCP scheduling procedures must ensure that health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of enrollment.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
The PH-MCO must provide the Department with its protocol for ensuring that a Member's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
The PH-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
The PH-MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the PH-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Member is already in active care with a PCP or specialist.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
The PH-MCO must make a reasonable effort to schedule an appointment with a PCP or specialist within forty-five (45) days of Enrollment for any Member who is an SSI or SSI-related consumer unless the Member is already in active care with a PCP or specialist.	Primary care providers	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual

Pennsylvania Network Access Standards	Applicable Provider Types	Network Adequacy Indicator	Definition of Network Adequacy Indicator	Network Adequacy Indicator Data Source
For specialty referrals, the PH-MCO must be able to provide for Emergency Medical Condition appointments immediately upon referral.	Specialists	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
For specialty referrals, the PH-MCO must be able to provide for Urgent Medical Condition care appointments within twenty-four (24) hours of referral.	Specialists	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
For specialty referrals, the PH-MCO must be able to provide for scheduling of appointments for routine care within fifteen (15) business days.	Otolaryngology, Orthopedic Surgery, Dermatology, Pediatric Allergy & Immunology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, Pediatric Urology, Dentist Pediatric Dentistry	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
The MCO schedules appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.	All other specialty provider types not listed above.	Reviewed and approved policies and procedures	Total MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members: First trimester – within ten (10) Business Days of the Member being identified as being pregnant.	OB/GYN or Certified Nurse Midwife	Reviewed and approved policies and procedures	Total birthing MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members: Second trimester – within five (5) Business Days of the Member being identified as being pregnant.	OB/GYN or Certified Nurse Midwife	Reviewed and approved policies and procedures	Total birthing MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual

Pennsylvania Network Access Standards	Applicable Provider Types	Network Adequacy Indicator	Definition of Network Adequacy Indicator	Network Adequacy Indicator Data Source
Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members: Third trimester – within four (4) Business Days of the Member being identified as being pregnant.	OB/GYN or Certified Nurse Midwife	Reviewed and approved policies and procedures	Total birthing MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members: High-risk pregnancies – within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists.	OB/GYN or Certified Nurse Midwife	Reviewed and approved policies and procedures	Total birthing MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual
EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations. The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.	Primary care providers	Reviewed and approved policies and procedures	Total EPSDT MA Population: Covered by Policy and Procedures, Evidence of Oversight of Compliance through Quality Improvement Program, Practitioner and Provider Education, Member Education, Complaints and Grievance (Policy and Procedure)	Provider Manual

PCP: primary care physician, MCO: managed care organization; PH: physical health; HIV: human immunodeficiency virus; AIDS: acquired immunodeficiency syndrome; ob/gyn: obstetrician/gynecologist; EAP: enrollment assistance program, EPSDT: Early and Periodic Screening, Diagnosis, and Treatment.

Conclusions and Comparative Findings

Network standards and access-related requirements can be categorized into four types: (1) time and distance standards; (2) timely access standards, such as appointment wait times; (3) provider-to-enrollee ratios: and (4) other standards, such as those related to physical and cultural accessibility. All four types are important to ensure that Medicaid and CHIP beneficiaries can receive timely and adequate access to services.[18]

The Commonwealth of Pennsylvania has established network adequacy standards, indicators, and data sources for all four network adequacy categories that are tailored to Pennsylvania HealthChoices members and services covered by the program and adapted to Pennsylvania's geographic and provider context.

[18] Lipson, D.J., Libersky, J., Bradley, K., Lewis, C., Siegwarth, A.W., and Lester, R. (2017). *Promoting access in Medicaid and CHIP managed care: A toolkit for ensuring provider network adequacy and service availability*. Division of Managed Care Plans, Center for Medicaid and CHIP Services, CMS, U.S. Department of Health and Human Services. Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability (nv.gov).

VI. Validation of Quality-of-Care Surveys – CAHPS Member Experience Survey

Objectives

Title 42 CFR § 438.358(c)(2) establishes that for each MCO, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *Title 42 CFR §* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual EQR.

The Pennsylvania DHS requires MCOs to sponsor a member experience survey annually. The goal of the survey is to get feedback from these members about how they view the health care services they receive. DHS uses results from the survey to determine variation in member satisfaction among the MCOs. Further, Exhibit M(1), Standard III(I) of the HealthChoices Agreement requires that the CAHPS survey tools be administered.

The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of care provided.

Each MCO independently contracted with a certified CAHPS vendor to administer the adult and child surveys for MY 2022.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for Pennsylvania's HealthChoices program were the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey.

HEDIS specifications require that the MCOs provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the MCOs included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2022, who were continuously enrolled for at least five of the last six months of 2022, and who are currently enrolled in the MCO.

Results were calculated in accordance with HEDIS specifications for survey measures. According to HEDIS specifications, results for the adult and child populations were reported separately, and no weighting or case-mix adjustment was performed on the results.

For the global ratings, composite measures, composite items, and individual item measures, the scores were calculated using a 100-point scale. Responses were classified into response categories. **Table 35** displays these categories and the measures by which these response categories are used.

Table 35: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite measures	
• Getting Needed Care • Getting Care Quickly • How Well Doctors Communicate • Customer Service	Never, sometimes, usually, always (Top-level performance is considered responses of "usually" or "always.")
Global rating measures	
• Rating of All Health Care • Rating of Personal Doctor • Rating of Specialist Talked to Most Often • Rating of Health Plan • Rating of Treatment or Counseling	0–10 scale (Top-level performance is considered scores of "8" or "9" or "10.")

CAHPS: Consumer Assessment of Healthcare Providers and Systems.

To assess MCO performance, IPRO compared MCO scores to national Medicaid performance reported in the 2023 Quality Compass® (MY 2022) for all lines of business that reported MY 2022 CAHPS data to NCQA.

Description of Data Obtained

For each MCO, IPRO received a copy of the final MY 2022 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as MCO-level results and analyses.

Conclusions and Comparative Findings

Table 36 and **Table 37** provide the survey results of four composite questions by two specific categories for KF across the last three MYs, as available. The composite questions target the MCO's performance strengths as well as opportunities for improvement.

Table 36: CAHPS MY 2022 Adult Survey Results

Survey Section/Measure	MY 2022	MY 2022 Rate Compared to MY 2021	MY 2021	MY 2021 Rate Compared to MY 2020	MY 2020	MY 2022 MMC Weighted Average
Your health plan						
Satisfaction with Adult's Health Plan (Rating of 8–10)	80.33%	▼	82.64%	▲	80.66%	81.33%
Getting Needed Information (Usually or Always)	82.98%	▲	77.88%	▼	83.84%	84.33%
Your health care in the last 6 months						
Satisfaction with Health Care (Rating of 8–10)	84.52%	▲	80.63%	▲	80.50%	78.54%
Appointment for Routine Care When Needed (Usually or Always)	81.01%	▲	76.22%	▲	75.31%	81.49%

▲▼ = Performance increased (▲) or decreased (▼) compared to prior year's rate.
Gray-shaded boxes reflect rates above the MY 2022 MMC weighted average.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid managed care.

Table 37: CAHPS MY 2022 Child Survey Results

Survey Section/Measure	MY 2022	MY 2022 Rate Compared to MY 2021	MY 2021	MY 2021 Rate Compared to MY 2020	MY 2020	MY 2022 MMC Weighted Average
Your child's health plan						
Satisfaction with Child's Health Plan (Rating of 8–10)	89.86%	▲	87.84%	▼	89.71%	88.80%
Information or Help from Customer Service (Usually or Always)	83.33%	=	83.33%	▲	81.48%	83.06%
Your healthcare in the last 6 months						
Satisfaction with Health Care (Rating of 8–10)	84.48%	▼	86.86%	▼	90.71%	87.10%
Appointment for Routine Care When Needed (Usually or Always)	78.03%	▼	79.38%	▲	76.50%	84.91%

▲▼ = Performance increased (▲) or decreased (▼) compared to prior year's rate.
Gray-shaded boxes reflect rates above the MY 2022 MMC weighted average.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid managed care.

VII. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each ATR include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 38** displays the MCO's opportunities, as well as IPRO's assessment of their responses. The detailed responses are included in the embedded document. In addition to the opportunities identified from the EQR, DHS also required MCOs to develop a root cause analysis around select Pay-for-Performance (P4P) indicators.

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each PH-MCO has addressed the opportunities for improvement made by IPRO in the 2022 EQR ATRs, which were distributed May 2023. The 2022 EQR is the fifteenth to include descriptions of current and proposed interventions from each PH-MCO that address the recommendations from the prior year's reports.

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

- follow-up actions that the MCO has taken through June 30, 2023, 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 2023, as well as any additional relevant documentation provided by KF

The embedded document presents KF's responses to opportunities for improvement cited by IPRO in the 2022 EQR ATR, detailing current and proposed interventions.

KF 2022 Opps
Response Request Fo

Root Cause Analysis and Action Plan

The 2023 EQR is the fourteenth year MCOs were required to prepare a root cause analysis and action plan for measures on the HEDIS MY 2022 P4P Measure Matrix receiving either "D" or "F" ratings. Each P4P measure in categories "D" and "F" required that the MCO submit:

- a goal statement;
- a root cause analysis and analysis findings;
- an action plan to address findings;
- implementation dates; and
- a monitoring plan to ensure action is effective and to address what will be measured and how often that measurement will occur.

KF submitted an initial root cause analysis and action plan in September 2023. For each measure in grade categories D and F, KF completed the embedded form, identifying factors contributing to poor performance.

2022
Root_Cause_Analysis_I

For the 2022 EQR, KF was required to prepare a root cause analysis and action plan for the following performance measures, which are detailed in **Table 38**.

KF Response to Previous EQR Recommendations

Table 38 displays KF's progress related to the *2022 External Quality Review Report,* as well as IPRO's assessment of KF's response.

Table 38: KF Response to Previous EQR Recommendations

Recommendation for KF	IPRO Assessment of MCO Response[1]
Improve Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44 years)	Remains an opportunity for improvement
Improve Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12–17 years)	Remains an opportunity for improvement
Improve Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1–17 years)	Remains an opportunity for improvement
Improve Well-Child Visits in the First 30 Months of Life (Ages 15 months ≥ 6 Visits)	Partially addressed
Improve Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	Remains an opportunity for improvement
Improve Follow-Up Care for Children Prescribed ADHD Medication (BH Enhanced) – Initiation Phase	Remains an opportunity for improvement
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years – ED visits for mental illness, follow-up within 7 days)	Remains an opportunity for improvement
Improve Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages 18 to 64 years – ED visits for mental illness, follow-up within 30 days)	Remains an opportunity for improvement
Improve Sealant Receipt on Permanent First Molars (≥ 1 Molar)	Remains an opportunity for improvement
Improve Sealant Receipt on Permanent First Molars (All 4 Molars)	Remains an opportunity for improvement
Improve Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15–20 years)	Remains an opportunity for improvement
Improve Prenatal Counseling for Smoking	Partially addressed
Improve Prenatal Counseling for Environmental Tobacco Smoke Exposure	Addressed
Improve Prenatal Screening Positive for Depression	Partially addressed
Improve Prenatal Counseling for Depression	Partially addressed
Improve Appropriate Testing for Pharyngitis (Ages 18–64 years)	Addressed
Improve Appropriate Testing for Pharyngitis (Total)	Partially addressed

Recommendation for KF	IPRO Assessment of MCO Response[1]
Improve Appropriate Treatment for Upper Respiratory Infection (Ages 18–64 years)	Remains an opportunity for improvement
Improve Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	Addressed
Improve Asthma in Younger Adults Admission Rate (Ages 2–17 years) Admissions per 100,000 member months	Addressed
Improve Asthma in Younger Adults Admission Rate (Ages 18–39 years) Admissions per 100,000 member months	Partially addressed
Improve Asthma in Younger Adults Admission Rate (Total Ages 2–39 years) Admissions per 100,000 member months	Addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40–64 years) Admissions per 100,000 member months	Partially addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Ages 40+ years) Admissions per 100,000 member months	Partially addressed
Improve HbA1c Poor Control (> 9.0%)	Measure retired
Improve Blood Pressure Controlled < 140/90 mm Hg	Measure retired
Improve Diabetes Short-Term Complications Admission Rate (Ages 18–64 years) Admissions per 100,000 member months	Partially addressed
Improve Diabetes Short-Term Complications Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Partially addressed
Improve Controlling High Blood Pressure (Total Rate)	Measure retired
Improve Heart Failure Admission Rate (Ages 18–64 years) Admissions per 100,000 member months	Partially addressed
Improve Heart Failure Admission Rate (Total Ages 18+ years) Admissions per 100,000 member months	Partially addressed
Improve Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Ages 40–75 years (Female)	Addressed
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 1–11 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Ages 12–17 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (Total Ages 1–17 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing (Total Ages 1–17 years)	Partially addressed
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 1–11 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Ages 12–17 years)	Remains an opportunity for improvement
Improve Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose & Cholesterol Testing (Total Ages 1–17 years)	Remains an opportunity for improvement
Improve Use of Opioids at High Dosage	Partially addressed
Improve Concurrent Use of Opioids and Benzodiazepines (Total Ages 18 years and older)	Addressed
Improve Use of Pharmacotherapy for Opioid Use Disorder (Total)	Addressed

Recommendation for KF	IPRO Assessment of MCO Response[1]
Improve Use of Pharmacotherapy for Opioid Use Disorder (Buprenorphine)	Addressed

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

EQR: external quality review; MCO: managed care organization; ADHD: attention deficit hyperactivity disorder; BH: behavioral health; ED: emergency department; HbA1c: hemoglobin A1c.

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

Table 39 highlights the MCO's performance strengths and opportunities for improvement and this year's recommendations based on the aggregated results of state fiscal year 2023 EQR activities as they relate to **quality**, **timeliness**, and **access**.

KF Strengths, Opportunities for Improvement, and EQR Recommendations

Table 39: KF Strengths, Opportunities for Improvement, and EQR Recommendations

EQR Activity		Quality	Timeliness	Access
Strengths				
PIPs: Preventing Inappropriate Use or Overuse of Opioids	KF provided detailed aims and objectives and the study design specifies data collection methodologies that are valid and reliable, along with robust data analysis procedures. Six indicators had improved rates.	✓	✓	✓
PIPs: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Strengths of this PIP include the multiple member outreach initiatives undertaken to support African American members with diabetes and/or SPMI. Sustained improvement was evident in six of the nine performance indicators from baseline to the final measurement period.	✓	✓	✓
Performance Measures	KF reported measures that were statistically significantly better/above the MY 2022 MMC weighted average by at least three percentage points in the Access to/Availability of Care, Cardiovascular Conditions, Dental and Oral Health Services, Maternal and Perinatal Health, Overuse/Appropriateness, Prevention and Screening, and Respiratory Conditions categories.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 88 items evaluated for compliance, KF was compliant on all but one.	✓	✓	✓
Quality-of-Care Surveys	Three of four MY 2022 composite rates for the adult CAHPS survey improved compared to MY 2021.	✓	✓	✓
Opportunities				
PIPs: Preventing Inappropriate Use or Overuse of Opioids	Less than half of the indicators exhibited sustained improvement, prompting the need for a more comprehensive discussion on barrier analysis related to indicator rates for continuing interventions in the next PIP.	✓	✓	✓
PIPs: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	There is an opportunity to strengthen the PIP through expanded provider involvement. Some interventions' alignment with the aim and objectives lacked clarity. The lack of alignment impacted the validity of the interventions influence on performance improvement.	✓	✓	✓

EQR Activity		Quality	Timeliness	Access
Performance Measures	KF reported measures that were statistically significantly worse/below the MY 2022 MMC weighted average by at least three percentage points in the Access to/Availability of Care, Behavioral Health, Dental and Oral Health Services, Diabetes, Maternal and Perinatal Health, Overuse/Appropriateness, Prevention and Screening, Respiratory Conditions, and Utilization categories.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	KF was evaluated against 11 items for the Health Information Systems category and was compliant on 10 items and non-compliant on one item.	✓	✓	✓
Quality-of-Care Surveys	Two of four MY 2022 composite rates for the child CAHPS survey declined compared to MY 2021, and one rate remained the same.	✓	✓	✓
Recommendations				
PIPs: Preventing Inappropriate Use or Overuse of Opioids	Recommendations include the need for more detailed initial and ongoing barrier analyses and early intervention modification in subsequent PIP cycles, ensuring a timely review of trends.	✓	✓	✓
PIPs: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Recommendations include the need for more robust initial and ongoing barrier analyses that engaged providers. Based on the analyses, interventions should clearly align with the PIP aim, objectives, and performance indicators.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve access to and availability of care for adult dental visits, initiation and engagement of substance use disorder, psychosocial care for children and adolescents on antipsychotics, and preventive ambulatory health services.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve behavioral health care with a focus on the following areas: (1) medication adherence for members with schizophrenia, (2) follow-up after emergency department visit for member with mental illness, (3) pharmacotherapy for members with opioid use disorder, (4) depression screening and follow-up, (5) follow-up for children prescribed ADHD medication, and (6) metabolic monitoring for children on antipsychotics.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve dental and oral health services, particularly regarding sealant receipt on permanent first molars for its members.	✓	-	✓
Performance Measures	It is recommended that KF work to improve blood pressure control, eye exam availability, and hemoglobin A1c control for patients with diabetes.	✓	✓	✓

EQR Activity		Quality	Timeliness	Access
Performance Measures	It is recommended that KF focus on improvement on the following areas: (1) adult immunizations for Td/TDaP, (2) colorectal cancer screening, (3) follow-up for children prescribed ADHD medication, (4) metabolic monitoring for children on antipsychotics, and (5) follow-ups on positive depression screenings for postpartum members.	-	-	-
Performance Measures	It is recommended that KF work to improve maternal and perinatal health by focusing on access to contraceptive care for its members and smoking and depression screenings for its prenatal and postpartum members.	✓	✓	✓
Performance Measures	It is recommended that KF work to improve in the area of overuse and appropriateness by focusing on appropriate treatment for members with upper respiratory infection and member use of opioids at high dosage.	✓	-	-
Performance Measures	It is recommended that KF work to improve prevention and screening, particularly regarding colorectal cancer screenings for its members.	✓	-	✓
Performance Measures	It is recommended that KF work to improve care related to respiratory conditions with a focus on appropriate pharyngitis testing and asthma medication prescription.	✓	-	-
Performance Measures	It is recommended that KF focus on improvement regarding asthma related admissions for younger adults, COPD admissions in older adults, short-term admissions related to complications with diabetes, heart failure admissions, and ED and outpatient visit utilization for ambulatory care.	✓	-	✓
Compliance with Medicaid and CHIP Managed Care Regulations	It is recommended that KF work to address their partial compliance for the Health Information Services category.	✓	✓	✓
Quality-of-Care Surveys	It is recommended that KF improve child member satisfaction with a focus on information or help from customer service, satisfaction with healthcare, and obtaining an appointment for routine care when needed. Additionally, KF should focus on adult member satisfaction on the adult's health plan.	✓	✓	✓

EQR: external quality review; PIP: performance improvement project; CHIP: Children's Health Insurance Program; SPMI: serious persistent mental illness; MMC: Medicaid managed care; MY: measurement year; ED: emergency department; CAHPS: Consumer Assessment of Healthcare Providers and Systems; ADHD: attention deficit hyperactivity disorder; COPD: chronic obstructive pulmonary disease; Td/TDaP: diphtheria, tetanus, and whooping cough vaccination.

P4P Measure Matrix Report Card 2023 (MY 2022)

The P4P Matrix Report Card provides a comparative look at all measures in the Quality Performance Measures component of the "HealthChoices MCO Pay for Performance Program." There are 12 measures: seven are classified as both HEDIS and CMS Core Set measures, two are solely HEDIS, and one is solely a CMS Child Core Set measure. The matrix does the following:

1. compares the MCO's own P4P measure performance over the two most recent reporting years, MY 2022 and MY 2021; and
2. compares the MCO's MY 2022 P4P measure rates to the MY 2022 MMC weighted average, or the MCO average as applicable.

A matrix represents the comparisons in each of **Figures 1**–**2.** In **Figure 1**, the horizontal comparison represents the MCO's current performance as compared to the most recent MMC weighted average. When comparing an MCO's rate to the MMC weighted average for each respective measure, the MCO rate can be either above average, average, or below average. For each rate, the MCO's performance is determined using a 95% CI 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% CI. 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. Noted comparative differences denote statistically significant differences between the years.

Figure 2 represents a matrix for the Plan All-Cause Readmissions measure. Instead of a percentage, performance on this measure is assessed via a ratio of observed readmissions to expected readmissions. Additionally, an MMC weighted average is not calculated. Given the different parameters for this measure, comparisons are made based on absolute differences in the observed versus expected ratio between years and against the current year's MCO average.

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

The green box (A) indicates that performance is notable. The MCO's MY 2022 rate is above/better than the MY 2022 average and above/better than the MCO's MY 2021 rate.

The light green boxes (B) indicate either that the MCO's MY 2022 rate does not differ from the MY 2022 average and is above/better than MY 2021, or that the MCO's MY 2022 rate is above/better than the MY 2022 average but there is no change from the MCO's MY 2021 rate.

The yellow boxes (C) indicate that the MCO's MY 2022 rate is below/worse than the MY 2022 average and is above/better than the MY 2021 rate, or that the MCO's MY 2022 rate does not differ from the MY 2022 average and there is no change from MY 2021, or that the MCO's MY 2022 rate is above/better than the MY 2022 average but is lower/worse than the MCO's MY 2021 rate. No action is required, although MCOs should identify continued opportunities for improvement.

The orange boxes (D) indicate either that the MCO's MY 2022 rate is lower/worse than the MY 2022 average and there is no change from MY 2021, or that the MCO's MY 2022 rate is not different than the MY 2022 average and is lower/worse than the MCO's MY 2021 rate. ***A root cause analysis and plan of action is therefore required.***

The red box (F) indicates that the MCO's MY 2022 rate is below/worse than the MY 2022 average and is below/worse than the MCO's MY 2021 rate. ***A root cause analysis and plan of action is therefore required.***

KF Key Points

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

Measure(s) that in MY 2022 are statistically significantly above/better than MY 2021 and are statistically significantly above/better than the MY 2022 MMC weighted average:

- Developmental Screening in the First Three Years of Life

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

Measure(s) that in MY 2022 are statistically significantly above/better than MY 2021 but did not statistically significantly change from the MY 2022 MMC weighted average:

- Controlling High Blood Pressure

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

Measure(s) that in MY 2022 did not statistically significantly change from MY 2021 and are not statistically significantly different from the MY 2022 MMC weighted average:

- Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) [19]
- Lead Screening in Children
- Prenatal Care in the First Trimester
- Postpartum Care

Measure(s) that in MY 2022 are statistically significantly above/better than MY 2021 and are statistically significantly below/worse than the MY 2022 MMC weighted average:

- Well-Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits)

Measure(s) that in MY 2022 are statistically significantly below/worse than MY 2021 and are statistically significantly above/better than the MY 2022 MMC weighted average.

- Annual Dental Visit (Ages 2–20 years)
- Child and Adolescent Well-Care Visits (Ages 3–21 years)
- Plan All-Cause Readmissions[20]

[19] Lower rates for Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) indicate better performance.
[20] Lower rates for Plan All-Cause Readmissions indicate better performance.

- **D – Root cause analysis and plan of action required.**

Measure(s) that in MY 2022 did not statistically significantly change from MY 2021 but are statistically significantly lower/worse than the MY 2022 MMC weighted average:

- No P4P measures fell into this comparison category.

- **F – Root cause analysis and plan of action required.**

Measure(s) that in MY 2022 are statistically significantly lower/worse than MY 2021 and are statistically significantly lower/worse than the MY 2022 MMC weighted average:

- Asthma Medication Ratio

		Medicaid Managed Care Weighted Average Statistical Significance Comparison		
Year-to-Year Statistical Significance Comparison	**Trend**	**Below/Worse than Average**	**Average**	**Above/Better than Average**
	⬆	**C** Well-Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits)	**B** Controlling High Blood Pressure	**A** Developmental Screening in the First Three Years of Life
	No Change	**D**	**C** Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) Lead Screening in Children Prenatal Care in the First Trimester Postpartum Care	**B**
	⬇	**F** Asthma Medication Ratio	**D**	**C** Annual Dental Visit (Ages 2–20 years) Child and Adolescent Well-Care Visits (Ages 3–21 years)

Figure 1: P4P Measure Matrix – Rate Measures Lower rates for Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) indicate better performance. P4P: Pay-for-Performance.

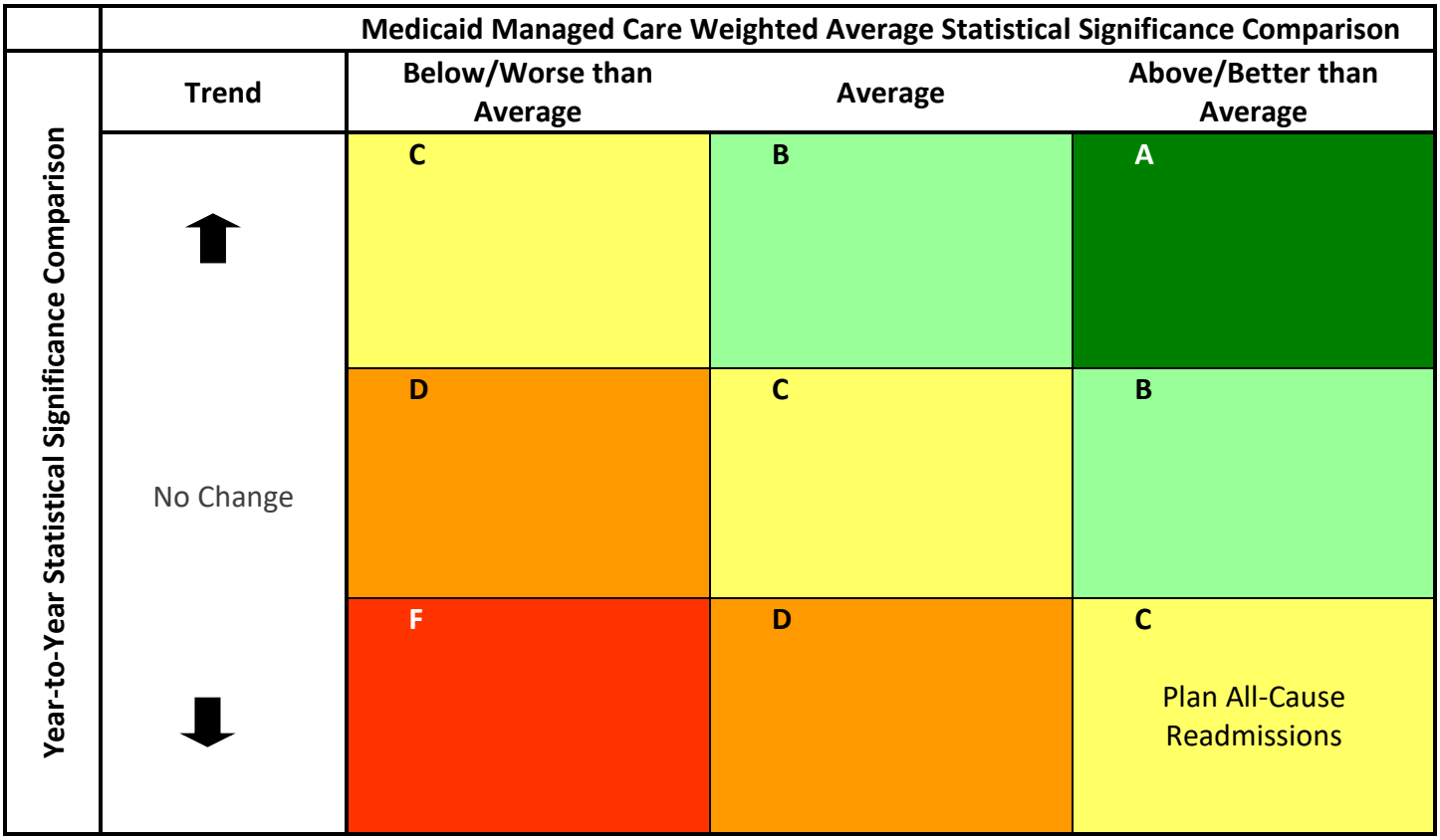

Figure 2: P4P Measure Matrix – PCR Ratio Measure Lower rates for Plan-All Cause Readmissions (PCR) indicate better performance. P4P: Pay-for-Performance.

P4P performance measure rates for MY 2019, MY 2020, MY 2021, and MY 2022 as applicable are displayed in **Table 40**. The following symbols indicate the differences between the reporting years:

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

Table 40: P4P Measure Rates

Quality Performance Measure – HEDIS Percentage Rate Metric[1]	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2022 MMC WA
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) [2]	34.3% =	41.9% ▲	42.1% =	36.3% =	32.3%
Controlling High Blood Pressure	64.0% =	51.6% ▼	55.5% =	65.9% ▲	70.3%
Prenatal Care in the First Trimester	93.9% ▲	87.1% ▼	87.8% =	87.1% =	88.7%
Postpartum Care	78.1% ▲	79.8% =	79.8% =	81.5% =	81.6%
Annual Dental Visits (Ages 2–20 years)	71.6% ▲	57.8% ▼	68.9% ▲	67.2% ▼	63.2%
Well–Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits)	71.5% =	59.2% ▼	57.9% =	64.2% ▲	68.1%
Child and Adolescent Well-Care Visits (Ages 3–21 years)	N/A	N/A	61.1% ▲	59.4% ▼	58.9%
Asthma Medication Ratio	N/A	64.6% ▲	66.6% ▲	64.2% ▼	66.3%
Lead Screening in Children	84.4% =	83.5% =	80.9% ▼	81.8% =	81.9%

Quality Performance Measure – HEDIS Percentage Rate Metric[1]	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2022 MMC WA
Quality Performance Measure – Other Percentage Rate Metric	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2022 MMC WA
Developmental Screening in the First Three Years of Life (CMS Child Core)	60.5% ▲	58.0% ▼	61.0% ▲	64.6% ▲	62.0%
Quality Performance Measure – HEDIS Ratio Metric	HEDIS MY 2019 Ratio	HEDIS MY 2020 Ratio	HEDIS MY 2021 Ratio	HEDIS MY 2022 Rate	HEDIS MY 2022 MCO Average
Plan All-Cause Readmissions[3]	N/A	1.19 ▼	1.15 =	1.13 =	0.96

[1] Statistically significant difference is indicated for all measures except Plan All–Cause Readmissions. For this measure, differences are indicated based on absolute differences in the observed-to-expected ratio between years.
[2] Lower rates for Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) indicate better performance.
[3] Lower rates for Plan All-Cause Readmissions indicate better performance.
P4P: Pay-for-Performance; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; MMC: Medicaid Managed Care; WA: weighted average; CMS: Centers for Medicare and Medicaid Services; MCO: managed care organization. N/A: not applicable, the measure was not included in the P4P program that measurement year.

IX. Appendix A

Performance Improvement Project Interventions

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

Table A1: PIP Interventions

Summary of Interventions
Keystone First (KF) – Opioid
1. Care Managers will outreach and educate the members with risk of continued use of opioids after 15 days (in a 30 day period) or 31 days (in a 62 day period). Outreach will be via phone and/or letter.
2. Bright Start maternity team will offer a home visitation program for all African American pregnant women with Opioid Use Disorder.
3. Emergency Room overdose follow-up: Rapid Response Outreach Team will make telephonic outreach to members identified through Health Information Exchanges, who have been to the Emergency Department with a diagnosis of overdose to assist with coordination of care and referral to appropriate resources.
4. Keystone First community facing teams will attempt to obtain consent forms from members with opioid use disorder when working with members in the community face to face.
5. Outreach to providers of members that are on both Opioids and Benzodiazepine.
6. Outreach to members newly initiated on buprenorphine to provide education and support to ensure adherence to prescribed regimen.
Keystone First (KF) – Readmission
1. ED High Utilizer Outreach enhanced with ADT activity automation. Automated activity for outreach is generated for high ED utilizers following an ED visit notification through Health Share Exchange. A Care Connector calls member, assesses needs, provides alternatives to ED, addresses barriers, and assists with making follow up appt. with PCP and/or specialist.
2. Rapid Response team to educate caregivers on appropriate use of Emergency Department and provide information on services available to be used instead of going to the ED.
3. Transitions of Care Pathway High risk Members discharged from Inpatient hospitalization are assigned to a Care Manager to call the member to complete medication reconciliation, provide education regarding condition, medications, and follow up care, and assist with making f/u appt, and ensuring transportation to appt.
4. City Life: Members will be able to schedule a telehealth appointment with a doctor when unable to access their own doctor. Availability of the program will be communicated to members by Care Manager's, Acute Care Transition (ACT) nurses embedded within hospital emergency departments, and the health plan Rapid Response Outreach Team (RROT). Upon completion of appointment, City Life will provide a summary of the telehealth appointment to the member's primary care provider, who will be able to coordinate further follow-up as needed.
5. Diabetes Pathway for members with SPMI. Members with a diagnosis of SPMI and diabetes will be assigned to a Care Manager to assess member's needs and barriers, educate member on condition, medications, PCP visit schedule/screening measures, and assist in resolving barriers. Focus will be on African American population.

X. Appendix B

Race and Ethnicity

NCQA added race and ethnicity stratification reporting guidelines for MY 2022 for the following measures:

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients With Diabetes
- Prenatal and Postpartum Care
- Child and Adolescent Well-Care Visits

Strengths are identified for MY 2022 Race and Ethnicity performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Ethnicity: Not Hispanic or Latino - 5.4 percentage points
  - Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control - Race: White - 8.5 percentage points

Opportunities for improvement are identified for MY 2022 Race and Ethnicity performance measures.

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Child and Adolescent Well-Care Visits - Race: Native Hawaiian and Other Pacific Islander - 16.5 percentage points
  - Colorectal Cancer Screening - Ethnicity: Hispanic or Latino - 7.2 percentage points
  - Colorectal Cancer Screening - Ethnicity: Not Hispanic or Latino - 4.9 percentage points
  - Colorectal Cancer Screening - Race: Two or More Races - 8.4 percentage points
  - Colorectal Cancer Screening - Race: White - 7.5 percentage points
  - Controlling High Blood Pressure - Ethnicity: Not Hispanic or Latino - 5.6 percentage points
  - Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (< 8%) - Ethnicity: Not Hispanic or Latino - 7.4 percentage points

As referenced in **Section III: Validation of Performance Measures**, **Table B1** lists all HEDIS Race and Ethnicity data reported by the MCO for the review year. Strengths and opportunities for these measures can be found in **Section III**.

Table B1: Race and Ethnicity Measure Data

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Child and Adolescent Well-Care Visits	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	61.2%	N/A
Child and Adolescent Well-Care Visits	Ethnicity: Hispanic or Latino	31,436	19,862	63.2%	62.6%	63.7%	61.2%	+
Child and Adolescent Well-Care Visits	Ethnicity: Not Hispanic or Latino	165,808	97,333	58.7%	58.5%	58.9%	58.3%	+
Child and Adolescent Well-Care Visits	Ethnicity: Unknown	0	0	N/A	N/A	N/A	55.8%	N/A
Child and Adolescent Well-Care Visits	Race: American Indian and Alaska Native	662	391	59.1%	55.2%	62.9%	57.7%	n.s.
Child and Adolescent Well-Care Visits	Race: Asian	14,805	9,691	65.5%	64.7%	66.2%	62.8%	+
Child and Adolescent Well-Care Visits	Race: Asked but No Answer	0	0	N/A	N/A	N/A	64.4%	N/A
Child and Adolescent Well-Care Visits	Race: Black or African American	98,695	56,439	57.2%	56.9%	57.5%	56.2%	+
Child and Adolescent Well-Care Visits	Race: Native Hawaiian and Other Pacific Islander	59	24	40.7%	27.3%	54.1%	57.2%	–
Child and Adolescent Well-Care Visits	Race: Some Other Race	0	0	N/A	N/A	N/A	61.8%	N/A
Child and Adolescent Well-Care Visits	Race: Two or More Races	29,997	18,872	62.9%	62.4%	63.5%	62.1%	+
Child and Adolescent Well-Care Visits	Race: Unknown	0	0	N/A	N/A	N/A	59.4%	N/A
Child and Adolescent Well-Care Visits	Race: White	53,026	31,778	59.9%	59.5%	60.3%	59.2%	+
Colorectal Cancer Screening	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	51.1%	N/A
Colorectal Cancer Screening	Ethnicity: Hispanic or Latino	4,288	1,528	35.6%	34.2%	37.1%	42.8%	–
Colorectal Cancer Screening	Ethnicity: Not Hispanic or Latino	48,687	16,399	33.7%	33.3%	34.1%	38.5%	–
Colorectal Cancer Screening	Ethnicity: Unknown	4	0	N/A	N/A	N/A	35.8%	N/A
Colorectal Cancer Screening	Race: American Indian and Alaska Native	222	78	35.1%	28.6%	41.6%	38.4%	n.s.

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Colorectal Cancer Screening	Race: Asian	6,880	2,877	41.8%	40.6%	43.0%	41.0%	n.s.
Colorectal Cancer Screening	Race: Asked but No Answer	0	0	N/A	N/A	N/A	42.2%	N/A
Colorectal Cancer Screening	Race: Black or African American	20,770	6,754	32.5%	31.9%	33.2%	34.2%	–
Colorectal Cancer Screening	Race: Native Hawaiian and Other Pacific Islander	29	10	N/A	N/A	N/A	49.0%	N/A
Colorectal Cancer Screening	Race: Some Other Race	0	0	N/A	N/A	N/A	38.9%	N/A
Colorectal Cancer Screening	Race: Two or More Races	4,896	1,569	32.1%	30.7%	33.4%	40.4%	–
Colorectal Cancer Screening	Race: Unknown	3	0	N/A	N/A	N/A	37.9%	N/A
Colorectal Cancer Screening	Race: White	20,179	6,639	32.9%	32.2%	33.6%	40.4%	–
Controlling High Blood Pressure	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	0.0%	N/A
Controlling High Blood Pressure	Ethnicity: Hispanic or Latino	37	28	75.7%	60.5%	90.9%	68.0%	n.s.
Controlling High Blood Pressure	Ethnicity: Not Hispanic or Latino	374	243	65.0%	60.0%	69.9%	70.6%	–
Controlling High Blood Pressure	Ethnicity: Unknown	0	0	N/A	N/A	N/A	70.4%	N/A
Controlling High Blood Pressure	Race: American Indian and Alaska Native	3	1	N/A	N/A	N/A	50.8%	N/A
Controlling High Blood Pressure	Race: Asian	39	31	79.5%	65.5%	93.4%	74.3%	n.s.
Controlling High Blood Pressure	Race: Asked but No Answer	0	0	N/A	N/A	N/A	58.9%	N/A
Controlling High Blood Pressure	Race: Black or African American	193	110	57.0%	49.7%	64.2%	58.3%	n.s.
Controlling High Blood Pressure	Race: Native Hawaiian and Other Pacific Islander	0	0	N/A	N/A	N/A	60.0%	N/A
Controlling High Blood Pressure	Race: Some Other Race	0	0	N/A	N/A	N/A	58.0%	N/A
Controlling High Blood Pressure	Race: Two or More Races	37	29	78.4%	63.8%	93.0%	74.3%	n.s.
Controlling High Blood Pressure	Race: Unknown	0	0	N/A	N/A	N/A	63.1%	N/A
Controlling High Blood Pressure	Race: White	139	100	71.9%	64.1%	79.8%	76.4%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	0.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Hispanic or Latino	44	25	56.8%	41.0%	72.6%	52.7%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Not Hispanic or Latino	367	190	51.8%	46.5%	57.0%	59.1%	–
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Unknown	0	0	N/A	N/A	N/A	55.3%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: American Indian and Alaska Native	5	2	N/A	N/A	N/A	48.2%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Asian	45	29	64.4%	49.3%	79.5%	65.9%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Asked but No Answer	0	0	N/A	N/A	N/A	62.9%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Black or African American	188	92	48.9%	41.5%	56.4%	53.1%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Native Hawaiian and Other Pacific Islander	1	0	N/A	N/A	N/A	75.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Some Other Race	0	0	N/A	N/A	N/A	56.6%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Two or More Races	45	27	60.0%	44.6%	75.4%	65.5%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Unknown	0	0	N/A	N/A	N/A	54.9%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: White	127	65	51.2%	42.1%	60.3%	58.7%	n.s.

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	50.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Hispanic or Latino	44	13	29.6%	14.9%	44.2%	35.7%	n.s.
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Not Hispanic or Latino	367	136	37.1%	32.0%	42.1%	31.6%	+
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Unknown	0	0	N/A	N/A	N/A	34.6%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: American Indian and Alaska Native	5	2	N/A	N/A	N/A	16.2%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Asian	45	7	15.6%	3.9%	27.3%	19.8%	n.s.
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Asked but No Answer	0	0	N/A	N/A	N/A	29.4%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Black or African American	188	77	41.0%	33.7%	48.3%	37.7%	n.s.
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Native Hawaiian and Other Pacific Islander	1	1	N/A	N/A	N/A	25.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Some Other Race	0	0	N/A	N/A	N/A	34.1%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Two or More Races	45	11	24.4%	10.8%	38.1%	26.2%	n.s.
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Unknown	0	0	N/A	N/A	N/A	31.5%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: White	127	51	40.2%	31.2%	49.1%	31.7%	+
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	0.0%	N/A
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Hispanic or Latino	47	39	83.0%	71.2%	94.8%	83.8%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Not Hispanic or Latino	364	296	81.3%	77.2%	85.5%	81.1%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Unknown	0	0	N/A	N/A	N/A	75.8%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: American Indian and Alaska Native	1	1	N/A	N/A	N/A	52.7%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Asian	34	31	91.2%	80.2%	102.2%	89.5%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Race: Asked but No Answer	0	0	N/A	N/A	N/A	91.6%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Black or African American	225	185	82.2%	77.0%	87.4%	77.2%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Race: Native Hawaiian and Other Pacific Islander	0	0	N/A	N/A	N/A	75.0%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Some Other Race	0	0	N/A	N/A	N/A	86.5%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Two or More Races	40	32	80.0%	66.4%	93.6%	84.1%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Race: Unknown	0	0	N/A	N/A	N/A	86.1%	N/A

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Prenatal and Postpartum Care - Postpartum Care	Race: White	111	86	77.5%	69.3%	85.7%	82.3%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	0.0%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Hispanic or Latino	47	39	83.0%	71.2%	94.8%	89.8%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Not Hispanic or Latino	364	319	87.6%	84.1%	91.2%	88.5%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Unknown	0	0	N/A	N/A	N/A	80.0%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: American Indian and Alaska Native	1	1	N/A	N/A	N/A	50.8%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Asian	34	32	94.1%	84.7%	103.5%	91.7%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Asked but No Answer	0	0	N/A	N/A	N/A	92.8%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Black or African American	225	192	85.3%	80.5%	90.2%	85.6%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Native Hawaiian and Other Pacific Islander	0	0	N/A	N/A	N/A	75.0%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Some Other Race	0	0	N/A	N/A	N/A	90.2%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Two or More Races	40	32	80.0%	66.4%	93.6%	87.7%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Unknown	0	0	N/A	N/A	N/A	91.5%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: White	111	101	91.0%	85.2%	96.8%	90.2%	n.s.

[1] For comparison of MY 2022 rates to MMC rates, the "+" denotes that the plan rate exceeds the MMC rate, the "–" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates.
Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable, the denominator was less than 30.