Commonwealth Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

2018 External Quality Review Report
Geisinger Health Plan

Final Report
April 2019

IPRO
Better healthcare,
realized.

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Introduction

Purpose and Background

The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a MCO furnishes to Medicaid Managed Care recipients.

The EQR-related activities that must be included in detailed technical reports are as follows:

- review to determine MCO compliance with structure and operations standards established by the State (42 CFR §438.358),
- validation of performance improvement projects, and
- validation of MCO performance measures.

HealthChoices Physical Health (PH) is the mandatory managed care program that provides Medical Assistance recipients with physical health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) contracted with IPRO as its EQRO to conduct the 2018 EQRs for the HealthChoices PH MCOs and to prepare the technical reports. This technical report includes six core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
IV. 2017 Opportunities for Improvement – MCO Response
V. 2018 Strengths and Opportunities for Improvement
VI. Summary of Activities

For the PH Medicaid MCOs, the information for the compliance with Structure and Operations Standards section of the report is derived from the commonwealth's monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from the HealthChoices Agreement, and from National Committee for Quality Assurance (NCQA™) accreditation results for each MCO.

Information for Section II of this report is derived from activities conducted with and on behalf of DHS to research, select, and define Performance Improvement Projects (PIPs) for a new validation cycle. Information for Section III of this report is derived from IPRO's validation of each PH MCO's performance measure submissions. Performance measure validation as conducted by IPRO includes both Pennsylvania specific performance measures as well as Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures for each Medicaid PH MCO. Within Section III, CAHPS Survey results follow the performance measures.

Section IV, 2017 Opportunities for Improvement – MCO Response, includes the MCO's responses to the 2017 EQR Technical Report's opportunities for improvement and presents the degree to which the MCO addressed each opportunity for improvement.

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

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

I: Structure and Operations Standards

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

Methodology and Format

The documents used by IPRO for the current review include the HealthChoices Agreement, the SMART database completed by PA DHS staff as of December 31, 2017, and the most recent NCQA Accreditation Survey for GEI, effective December 2017.

The SMART items provided much of the information necessary for this review. The SMART items are a comprehensive set of monitoring items that PA DHS staff reviews on an ongoing basis for each Medicaid MCO. The SMART items and their associated review findings for each year are maintained in a database. The SMART database has been maintained internally at DHS since RY 2013. Upon receipt of the findings for RY 2017, IPRO and DHS discussed changes to the information included. First, the only available review conclusions were Compliant and non-Compliant. All other options previously available were re-designated in RY 2017 from review conclusion elements to review status elements and were therefore not included in the RY 2017 findings. Additionally, as of RY 2017, reviewers had the option to review zones covered by an MCO separately, and to provide multiple findings within a year (e.g., quarterly). As a result, there was an increase in the number of partially compliant items for RY 2017. Upon discussion with the DHS regarding the data elements from each version of database, IPRO merged the RY 2017, 2016, and 2015 findings for use in the current review. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 126 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS.

The crosswalk linked SMART Items to specific provisions of the regulations, where possible. Some items were relevant to more than one provision. It should be noted that one or more provisions apply to each of the categories in **Table 1.1**. Table 1.1 provides a count of items linked to each category.

Table 1.1: SMART Items Count Per Regulation

BBA Regulation	SMART Items
Subpart C: Enrollee Rights and Protections	
Enrollee Rights	7
Provider-Enrollee Communication	1
Marketing Activities	2
Liability for Payment	1
Cost Sharing	0
Emergency and Post-Stabilization Services – Definition	4
Emergency Services: Coverage and Payment	1
Solvency Standards	2
Subpart D: Quality Assessment and Performance Improvement	
Availability of Services	14
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 Systems	1
Subcontractual Relationships and Delegations	3
Practice Guidelines	2

BBA Regulation	SMART Items
Health Information Systems	18
Subpart F: Federal and State Grievance Systems Standards	
General Requirements	8
Notice of Action	3
Handling of Grievances and Appeals	9
Resolution and Notification	7
Expedited Resolution	4
Information to Providers and Subcontractors	1
Recordkeeping and Recording	6
Continuation of Benefits Pending Appeal and State Fair Hearings	2
Effectuation of Reversed Resolutions	0

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

Determination of Compliance

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO's compliance status with regard to the SMART Items. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights 438.100. 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.

Format

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol, i.e., Enrollee Rights and Protections; Quality Assessment and Performance Improvement (including access, structure and operation, and measurement and improvement standards); and Federal and State Grievance System Standards.

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

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

Findings

Of the 126 SMART Items, 80 items were evaluated and 46 were not evaluated for the MCO in Review Year (RY) 2017, RY 2016, or RY 2015. For categories where items were not evaluated for compliance for RY 2017, results from reviews conducted within the two prior years (RY 2016 and RY 2015) were evaluated to determine compliance, if available.

Subpart C: Enrollee Rights and Protections

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

Table 1.2: GEI Compliance with Enrollee Rights and Protections Regulations

ENROLLEE RIGHTS AND PROTECTIONS REGULATIONS		
Subpart C: Categories	**Compliance**	**Comments**
Enrollee Rights	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 6 items and was compliant on 6 items based on RY 2017.
Provider-Enrollee Communication	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Marketing Activities	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.
Liability for Payment	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Cost Sharing	Compliant	Per HealthChoices Agreement
Emergency Services: Coverage and Payment	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Emergency and Post Stabilization Services	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2017.
Solvency Standards	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.

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

Subpart D: Quality Assessment and Performance Improvement Regualtions

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

The SMART database includes an assessment of the MCO's compliance with regulations found in Subpart D. **Table 1.3** presents the findings by categories consistent with the regulations.

Table 1.3: GEI Compliance with Quality Assessment and Performance Improvement Regulations

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REGULATIONS		
Subpart D: Categories	**Compliance**	**Comments**
Access Standards		
Availability of Services	Partially Compliant	14 items were crosswalked to this category. The MCO was evaluated against 10 items and was compliant on 9 items and non-compliant on 1 item based on RY 2017.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 13 items and was compliant on 13 items based on RY 2017.
Coverage and Authorization of Services	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 7 items and was compliant on 7 items based on RY 2017.
Structure and Operation Standards		
Provider Selection	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Provider Discrimination Prohibited	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Confidentiality	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Enrollment and Disenrollment	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Grievance Systems	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Subcontractual Relationships and Delegations	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2017.
Measurement and Improvement Standards		
Practice Guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on 1 item based on RY 2017.
Health Information Systems	Compliant	18 items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on all 12 items based on RY 2017.

GEI was evaluated against 51 of 68 SMART Items that were crosswalked to Quality Assessment and Performance Improvement Regulations and was compliant on 50 items and non-compliant on 1 item. Of the 11 categories in Quality Assessment and Performance Improvement Regulations, GEI was found to be compliant on 10 categories and partially compliant on 1 category.

Subpart F: Federal and State Grievance System Standards

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

The Commonwealth's audit document information includes an assessment of the MCO's compliance with regulations found in Subpart F. **Table 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: GEI Compliance with Federal and State Grievance System Standards

FEDERAL AND STATE GRIEVANCE SYSTEM STANDARDS		
Subpart F: Categories	**Compliance**	**Comments**
General Requirements	Compliant	8 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Notice of Action	Compliant	3 items was crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.
Handling of Grievances & Appeals	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.
Resolution and Notification	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.
Expedited Resolution	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.
Information to Providers and Subcontractors	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Recordkeeping and Recording	Compliant	6 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.
Continuation of Benefits Pending Appeal and State Fair Hearings	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
Effectuation of Reversed Resolutions	Compliant	Per NCQA Accreditation, 2017

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

Accreditation Status

GEI underwent an NCQA Accreditation Survey effective through March 14, 2019 and was granted an Accreditation Status of Commendable.

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each Medicaid PH MCO. For the purposes of the EQR, PH MCOs were required to participate in studies selected by OMAP for validation by IPRO in 2018 for 2017 activities. Under the applicable HealthChoices Agreement with the DHS in effect during this review period, Medicaid PH MCOs are required to conduct focused studies each year. For all PH MCOs, two new PIPs were initiated as part of this requirement. For all PIPs, PH MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the new EQR PIP cycle that was initiated for all PH MCOs in 2015, PH MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: "Improving Access to Pediatric Preventive Dental Care" and "Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits".

"Improving Access to Pediatric Preventive Dental Care" was selected because on a number of dental measures, the aggregate HealthChoices rates have consistently fallen short of established benchmarks, or have not improved across years. For one measure, the HEDIS Annual Dental Visit (ADV) measure, from HEDIS 2006 through HEDIS 2013, the Medicaid Managed Care (MMC) average was below the 50th percentile for three years. Further, CMS reporting of FFY 2011-2013 data from the CMS-416 indicates that while PA met its two-year goal for progress on preventive dental services, the percentage of PA children age 1-20 who received any preventive dental service for FFY 2013 (40.0%), was below the National rate of 46.0%. The Aim Statement for the topic is "Increase access to and utilization of routine dental care for pediatric Pennsylvania HealthChoices members." Four common objectives for all PH MCOs were selected:

1. Increase dental evaluations for children between the ages of 6 months and 5 years.
2. Increase preventive dental visits for all pediatric HealthChoices members.
3. Increase appropriate topical application of fluoride varnish by non-oral health professionals.
4. Increase the appropriate application of dental sealants for children ages 6-9 (CMS Core Measure) and 12-14 years.

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

- Adapted from CMS form 416, the percentage of children ages 0-1 who received, in the last year:
  - any dental service,
  - a preventive dental service,
  - a dental diagnostic service,
  - any oral health service,
  - any dental or oral health service
- Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider
- Total Eligibles Receiving Preventive Dental Services
- The percentages of children, stratified by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who received at least one topical application of fluoride.

Additionally, MCOs are encouraged to consider other performance measures such as:

- Percentage of children with ECC who are disease free at one year.
- Percentage of children with dental caries (ages 1-8 years of age).
- Percentage of oral health patients that are caries free.
- Percentage of all dental patients for whom the Phase I treatment plan is completed within a 12 month period.

"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits" was selected as the result of a number of observations. General findings and recommendations from the PA Rethinking Care Program (RCP) – Serious Mental Illness (SMI) Innovation Project (RCP-SMI) and Joint PH/BH Readmission projects, as well as overall Statewide readmission rates and results from several applicable Healthcare Effectiveness Data and Information Set (HEDIS) and PA Performance Measures across multiple years, have highlighted this topic as an area of concern to be addressed for improvement. The Aim Statement for the topic is "To reduce potentially avoidable ED visits

and hospitalizations, including admissions that are avoidable initial admissions and readmissions that are potentially preventable." Five common objectives for all PH MCOs were selected:

1. Identify key drivers of avoidable hospitalizations, as specific to the MCO's population (e.g., by specific diagnoses, procedures, comorbid conditions, and demographics that characterize high risk subpopulations for the MCO).
2. Decrease avoidable initial admissions (e.g., admissions related to chronic or worsening conditions, or identified health disparities).
3. Decrease potentially preventable readmissions (e.g., readmissions related to diagnosis, procedure, transition of care, or case management)
4. Decrease avoidable ED visits (e.g., resulting from poor ambulatory management of chronic conditions including BH/SA conditions or use of the ED for non-urgent care).
5. Demonstrate improvement for a number of indicators related to avoidable hospitalizations and preventable readmissions, specifically for Individuals with Serious Persistent Mental Illness (SPMI).

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

MCO-developed Performance Measures

MCOS are required to develop their own indicators tailored to their specific PIP (i.e., customized to the key drivers of avoidable hospitalizations identified by each MCO for its specific population).

DHS-defined Performance Measures

- Ambulatory Care (AMB): ED Utilization. The target goal is 72 per 1,000 member months.
- Inpatient Utilization—General Hospital/Acute Care (IPU): Total Discharges. The target goal is 8.2 per 1,000 months.
- Reducing Potentially Preventable Readmissions (RPR). The target for the indicator is 8.5. This measure replaced the originally designated measure – Plan All-Cause Readmissions (PCR): 30-day Inpatient Readmission.
- Each of the five (5) BH-PH Integrated Care Plan (ICP) Program measures:
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  - Emergency Room Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
  - Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
  - Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI).

The PIPs extend from January 2015 through December 2018; with research beginning in 2015, initial PIP proposals developed and submitted in first quarter 2016, and a final report due in June 2019. The non-intervention baseline period is January 2015 to December 2015. Following the formal PIP proposal, the timeline defined for the PIPs includes required interim reports in July 2016, June 2017 and June 2018, as well as a final report in June 2019. Based on validation findings in 2016, the timeline has undergone adjustments.

The 2018 EQR is the fifteenth year to include validation of PIPs. For each PIP, all PH MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions and timeliness.

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

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

Validation Methodology

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by the Centers for Medicare & Medicaid Services (CMS) (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on EQR of Medicaid MCOs issued on January 24, 2003. IPRO's review evaluates each project against ten review elements:

1. Project Topic And Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation Of Study Results (Demonstrable Improvement)
9. Validity Of Reported Improvement
10. Sustainability Of Documented Improvement

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

Review Element Designation/Weighting

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

Table 2.1 presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1: Element Designation

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

Overall Project Performance Score

The total points earned for each review element are weighted to determine the MCO's overall performance score for a PIP. For the EQR PIPs, the review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance; **Table 2.2**).

PIPs also are reviewed for the achievement of sustained improvement. For the EQR PIPs, this has a weight of 20%, for a possible maximum total of 20 points (**Table 2.2**). The MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of "Met", "Partially Met", or "Not

Met". Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%.

Table 2.2: Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic and Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4/5	Identified Study Population and Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8/9	Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	20%
Total Demonstrable Improvement Score		80%
10	Sustainability of Documented Improvement	20%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

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. The multiple levels of activity and collaboration between DHS, the PH MCOs, and IPRO have continued and progressed throughout the PIP cycle.

Throughout 2016, the initial year of the cycle, there were several levels of feedback provided to MCOs, including:

- An overall summary document outlining common issues that were observed across most of the PIP proposal submissions.
- MCO-specific review findings for each PIP.
- Conference calls with each MCO to discuss the PIP proposal review findings with key MCO staff assigned to each PIP topic. MCOs were asked to complete a PIP Proposal Update form following the calls.
- An Interactive Workshop held with all MCOs at the end of August. MCOs were requested to come to the workshop with PIP project summaries that they were to present, which were later submitted to IPRO and distributed to all PH MCOs.
- Information to assist MCOs in preparing their next full PIP submission for the Project Year 1 Update, such as additional instructions regarding collection of the core required measures, three years of CMS-416 Reports with PA state aggregate data and the excerpt on oral health from the 2015 CMS Secretary's report with CMS OHI all-state data from FFY 2014 for MCOs to calculate appropriate benchmarks, and data for all five ICP measures.

In 2017, reviews of the Project Year 1 Update documents submitted in late 2016 were completed. Upon initial review of the submissions, MCOs were provided findings for each PIP with request for clarification/revision as necessary. MCOs requiring additional discussion and potential modification were contacted for individual MCO conference calls. Upon completion of applicable resubmissions, MCOs were provided with their final Project Year 1 Update review findings. Following completion of Project Year 1 Update reviews, MCOs were asked to submit a Year 2 Interim Update providing information through June 30 for: 1) interventions implemented, 2) monitoring, or process measure, results, and 3) any performance measure outcome results. Review findings were incorporated into the form, and completed reviews were posted to IPRO's FTP.

For the current review year, 2018, MCOs were requested to submit a full Project Year 3 Update, to include all updated Year 2 information and Year 3 activities to date. MCOs were asked to update their submission with the following information: 1) Final rates for all performance measures for Measurement Year (MY) 2016 (1/1/16-12/31/16), including the rates provided to them for the ICP measures, 2) any available rates MY 2017 (1/1/17-12/31/17); 3) an updated interventions grid to show interventions completed in 2017 and interventions completed to date in 2018; 4)

rates/results as appropriate for the process measures utilized to evaluate each of the ongoing interventions; 5) any additional supporting analysis conducted for the PIP.

Improving Access to Pediatric Preventive Dental Care

For the Dental PIP, GEI received full credit for review element 1. The MCO provided a detailed rationale for topic selection, including member specific HEDIS data for annual dental visits. The MCO stated that their rate "lags significantly from the National 95th percentile of 68.34%," showing there is room for improvement. GEI also performed an extensive literature review to identify barriers in dental care on a national and state level. GEI cited literature indicating that that a "caregiver's poor oral health was directly correlated with the probability of if and how a child of lower socioeconomic status would ultimately enter the dental care system. These children tended to get an initial visit older than recommended and generally with an urgent dental problem or concern, rather than having regular dental screenings to keep teeth and gums healthy. Suggestions were to engage families/caregivers in a culturally and linguistically sensitive way while also considering issues such as health literacy." The MCO addressed a wide variety of contributors to health for their members, and noted in its Aim statement that the MCO is looking to "develop population-based health interventions that benefit all members, irrespective of socio-economic status, resource, or past health behaviors." – indicating that the MCO is attempting to address a broad spectrum of key aspects of enrollee care.

GEI received partial credit for review elements 2 through 5. For the Aim statement, the MCO was advised to add study questions. The MCO listed the measureable short-term and long-term goals to achieve a 5% increase in the HEDIS rates for Annual Dental Visits for each age group in year one, and an ultimate goal of HEDIS 2015 95th percentile benchmark of 68.34% by the end of year three. However, the MCO specified a goal for Annual Dental Visits, and it was noted that study questions should be included with target goals for improvement corresponding to other core measures, such as noted in the CMS form 416, fluoride varnish, and dental sealants. This issue remained in the 2017 Interim Update and the Project Year 3 Update. The designation for review element 2 was changed to non-compliant.

The MCO indicated that they will be using HEDIS and reviewing the annual dental visit rate for each age group through claims data they receive from their vendor Avesis. The MCO is using reliable measures from HEDIS that will measure process of care for members with strong associations of improved outcomes. However, GEI needed to also define and address the Core Measures for this PIP, as well as include process measures. The MCO did not define the specifications for all measures, including the eligible populations and definitions of the numerators and denominators. The MCO specified that data and reporting will be for the entire eligible population for each measure and sub-measure.

GEI received full credit for review elements 6 and 7. Regarding its data analysis plan, GEI stated that HEDIS methodology will be used. Avesis will be providing the data and "the MCO's Clinical Informatics Department will coordinate these inputs and match up against assigned provider data in Amisys, as well as ongoing claims feeds to determine which intervention sources was responsible for each success or failure in the process. Tracking the compliance rates for each intervention will be compiled and reported to the MCO's Quality Workgroup on a semi-annual [basis]."

GEI explained that they identified barriers within their MCO through analysis of the available claims data, interviews with their Dental vendor and GHP's Community Health Assistants. The MCO provided a full description of each barrier identified and how the MCO identified it. GEI developed a diverse group of interventions to help improve care for their members and address the barriers. As some interventions appeared to still be pending, it was recommended that they be initiated as soon as possible in order to have an impact on remeasurement rates. Additionally, a few different programs were mentioned throughout the interventions, and the MCO subsequently clarified which programs were already existing programs and which were new programs for interventions created for this PIP. Finally, GEI was advised that interventions will need associated process measures in order to track their effectiveness on the PIP goals. In the 2017 Interim Update, it was noted that more clarity was needed for several interventions, both in terms of the detail provided and the number of members targeted. It was noted that more detail was needed regarding how the population would be reached. For example, in the Dental PIP, GEI listed the intervention "Connect the DOTS Program," conducted by AVESIS to educate pediatric dentists on how to perform dental care for members under three years old. It was unclear, however, how the education is provided and if there is follow-up. It was also noted that there should be a monitoring (tracking) measure for each intervention and the MCO was advised to clarify the association between the process measures and the interventions.

Review Element 8 was reviewed in 2018 and GEI received partial credit. In the 2017 Interim Update, it was observed that data sources and timeframes should be more clearly defined and presented. The outcome measure data were presented only for MCO-specific measures and did not include data for all applicable time periods. This issue remained in the Project Year 3 Update for 2018, and it was also noted that goals were not included. Due to the lack of data across measurement periods, review element 9 could not be assessed and remained "NA."

Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits

GEI received full credit for review elements 1 and 2. The MCO described its rationale for topic selection with some reference to findings in the literature, but was advised to cite the specific research. GEI demonstrated how integration of the BH-PH Integrated Care Plan Pay for Performance Program or the Community Based Care Management Program (CBCM) fits into the rationale for topic selection. The MCO used "recent data" to support topic selection, but subsequently clarified the time period of the data and the construct of the rates reported. GEI also identified top diagnoses for ER claims by costs and utilization. Several of these were diagnoses that may be managed in the PCP office. GEI listed four areas: URI, UTI, Acute Pharyngitis and Otitis Media and provided more detail for the process utilized for topic selection. Focus areas were identified using the top diagnoses for ER claims by cost and utilization.

Upon review of the Aim statement, GEI modified it to include a study question: was "Does Case Management or Special Needs Unit involvement with the member decrease potentially avoidable hospital admissions, readmissions and ED visits?" The MCO added goals to the Aim statement for the DHS-defined performance measures for this PIP and stated that "metrics will be measured using HEDIS specifications thus allowing comparisons with HEDIS driven benchmarks". GEI was advised to add such benchmark values to the AIM statement as targets.

GEI received partial credit for review element 3. GEI listed all of the core measures for the PIP and stated that "The Plan will continue to analyze the data and determine the reason for ER Visits, hospital admissions and readmissions and then identify if care in a different setting would be appropriate." The MCO was advised to expand on this and create MCO-developed performance and process measures to follow. GEI included a 30-day inpatient readmission measure, noted as internally developed, and included process measures in the subsequent barriers and interventions section. However, the specifications were not included for the core and MCO-defined measures. There were no definitions including eligible population, denominators and numerators.

GEI received full credit for review elements 4 and 5. The MCO included discussion of sampling specifications and added statements to the methodology that noted all PIP measures are administrative and no sampling is being used. The MCO was requested to clarify that this includes the PIP Process Measures, and to update sampling statements if applicable once the MCO developed performance measures were added to the PIP.

GEI received partial credit for review element 6. The MCO noted a general data analysis plan in their proposal: "The Admission, readmission and ER visit data and membership data will be pulled from Recast. For the slice and dice reporting, the membership and the utilization are pulled for a year's timeframe. Once this is summarized the utilization data is divided by the membership and then multiplied by 12,000. This provides the per 1000 rate. This is consistent across admissions, readmissions and ER." The analysis plan also did not include all DHS-defined performance measures and all MCO-developed performance and process measures, including a description of the data collection sources for these measures. Additionally, GEI included a graph to outline its process for data validation. However, it only described the internal process for collecting and reviewing measures. This did not address any external efforts to ensure data reliability and validity (e.g., any vendor data received, any external validation, etc.).

GEI received full credit for review element 7. The MCO presented a well-organized chart of Interventions and Barriers addressed. GEI included at least one new or enhanced intervention associated with each PIP initiative and for the ICP/CBCM programs. GEI also clarified changes or enhancements made to interventions for the purposes of this PIP. However, the process measure data had no associated timeframes reported. GEI was advised that process measures should be monitored monthly or at least quarterly to have the data available to monitor intervention effectiveness. The MCO noted that although the current process measure data included were a snapshot, the plan is targeting quarterly monitoring. In the 2017 Interim Update, it was noted that more clarity was needed for several interventions, both in

terms of the detail provided and the number of members targeted. It was noted that more detail was needed regarding how the population would be reached. For the Readmission PIP, there were no end dates listed for the interventions, and there was no indication of whether they were ongoing. It was also noted that there should be a monitoring (tracking) measure for each intervention and the MCO was advised to clarify the association between the process measures and the interventions.

Review Element 8 was reviewed in 2018 and GEI received a non-compliant designation for this element. In the 2017 Interim Update, it was observed that data sources and timeframes should be more clearly defined and presented. The outcome measure data were presented for all measures but did not include data for all applicable time periods. This issue remained in the Project Year 3 Update for 2018, and it was also noted that the table was the same as the previous Interim Update. Due to the lack of data across measurement periods, review element 9 could not be assessed and remained "NA."

GEI's Project Year 3 compliance assessment by review element is presented in Table 2.3.

Table 2.3: GEI PIP Compliance Assessments

Review Element	Improving Access to Pediatric Preventive Dental Care	Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits
1. Project Topic and Topic Relevance	Full	Full
2. Study Question (Aim Statement)	Non-Compliant	Full
3. Study Variables (Performance Indicators)	Partial	Partial
4. & 5. Identified Study Population and Sampling Methods	Partial	Full
6. Data Collection Procedures	Full	Partial
7. Improvement Strategies (Interventions)	Full	Full
8. & 9. Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	Partial	Non-Compliant
10. Sustainability of Documented Improvement	NA	NA

The next full submission will occur in review year 2019 and will be the final submission. Collaboration between DHS and PH MCOs is expected to continue, and PH MCOs will continue to be asked to participate in multi-plan PIP update calls through the duration of the PIP as applicable to report on their progress or barriers to progress.

III: Performance Measures and CAHPS Survey

Methodology

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

The MCOs were provided with final specifications for the PA Performance Measures from December 2017 to June 2018. Source code, raw data and rate sheets were submitted by the MCOs to IPRO for review in 2018. 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. Pseudo code was reviewed by IPRO. Raw data were also reviewed for reasonability and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally MCOs were provided with comparisons to the previous year's rates and were requested to provide explanations for highlighted differences. For measures reported as percentages, differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates. For measures not reported as percentages (e.g. adult admission measures) differences were highlighted based only on statistical significance, with no minimum threshold.

For three PA performance Birth-related measures: Cesarean Rate for Nulliparous Singleton Vertex (CRS), Live Births Weighing Less Than 2,500 Grams (PLB), and Elective Delivery, rates for each of the measures were produced utilizing MCO Birth files in addition to the 2018 (MY 2017) Department of Health Birth File. IPRO requested, from each MCO, information on members with a live birth within the measurement year. IPRO then utilized the MCO file in addition to the most recent applicable PA Department of Health Birth File to identify the denominator, numerator and rate for the three measures.

HEDIS 2018 measures were validated through a standard HEDIS compliance audit of each PH MCO. This audit 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). A Final Audit Report was submitted to NCQA for each MCO. Because the PA-specific performance measures rely on the same systems and staff, no separate onsite review was necessary for validation of the PA-specific measures. IPRO conducts a thorough review and validation of source code, data and submitted rates for the PA-specific measures.

Evaluation of MCO performance is based on both PA-specific performance measures and selected HEDIS measures for the EQR. The following is a list of the performance measures included in this year's EQR report.

Table 3.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
HEDIS	Children and Adolescents' Access to PCPs (Age 12 - 24 months)
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months - 6 years)
HEDIS	Children and Adolescents' Access to PCPs (Age 7-11 years)
HEDIS	Children and Adolescents' Access to PCPs (Age 12-19 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 45-64 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 65+)
HEDIS	Adult Body Mass Index Assessment
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 5)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 6 to 11)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)
Well Care Visits and Immunizations	
HEDIS	Well-Child Visits in the First 15 Months of Life (6+ Visits)
HEDIS	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)

Source	Measures
HEDIS	Childhood Immunizations Status by Age 2 (Combination 2)
HEDIS	Childhood Immunizations Status by Age 2 (Combination 3)
HEDIS	Adolescent Well-Care Visits (Age 12 to 21 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 3-11 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 12-17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Total)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 3-11 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 12-17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Total)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 3-11 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 12-17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical Activity: (Total)
HEDIS	Immunizations for Adolescents (Combination 1)
EPSDT: Screenings and Follow up	
HEDIS	Lead Screening in Children (Age 2 years)
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) – Initiation Phase
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase
PA EQR	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (BH Enhanced) – Initiation Phase
PA EQR	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (BH Enhanced) – Continuation and Maintenance Phase
PA EQR	Developmental Screening in the First Three Years of Life – 1 year
PA EQR	Developmental Screening in the First Three Years of Life – 2 years
PA EQR	Developmental Screening in the First Three Years of Life – 3 years
PA EQR	Developmental Screening in the First Three Years of Life – Total
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for mental illness, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for mental illness, follow-up within 7 days)
Dental Care for Children and Adults	
HEDIS	Annual Dental Visit (Age 2-20 years)
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Ages 2-20 years)
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)

Source	Measures
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)
Women's Health	
HEDIS	Breast Cancer Screening (Age 50–74 years)
HEDIS	Cervical Cancer Screening (Age 21-64 years)
HEDIS	Chlamydia Screening in Women (Total Rate)
HEDIS	Chlamydia Screening in Women (Age 16-20 years)
HEDIS	Chlamydia Screening in Women (Age 21-24 years)
HEDIS	Non-Recommended Cervical Cancer Screening in Adolescent Females
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44)
Obstetric and Neonatal Care	
PA EQR	Frequency of Ongoing Prenatal Care – Greater than or Equal to 61% of Expected Prenatal Care Visits Received
PA EQR	Frequency of Ongoing Prenatal Care – Greater than or Equal to 81% of Expected Prenatal Care Visits Received
HEDIS	Prenatal and Postpartum Care - Timeliness of Prenatal Care
HEDIS	Prenatal and Postpartum Care - Postpartum Care
PA EQR	Prenatal Screening for Smoking
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS)
PA EQR	Prenatal Counseling for Smoking
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure (ETS)
PA EQR	Prenatal Smoking Cessation
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
PA EQR	Perinatal Depression Screening: Prenatal Screening Positive for Depression
PA EQR	Perinatal Depression Screening: Prenatal Counseling for Depression
PA EQR	Perinatal Depression Screening: Postpartum Screening for Depression
PA EQR	Perinatal Depression Screening: Postpartum Screening Positive for Depression
PA EQR	Perinatal Depression Screening: Postpartum Counseling for Depression
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Alcohol use
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Illicit drug use
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Prescribed or over-the-counter drug use
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Intimate partner violence
PA EQR	Behavioral Health Risk Assessment
PA EQR	Elective Delivery
Respiratory Conditions	
HEDIS	Appropriate Testing for Children with Pharyngitis
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator

Source	Measures
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 12-18 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 19-50 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 51-64 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Total)
HEDIS	Asthma Medication Ratio (5-11 years)
HEDIS	Asthma Medication Ratio (12-18 years)
HEDIS	Asthma Medication Ratio (19-50 years)
HEDIS	Asthma Medication Ratio (51-64 years)
HEDIS	Asthma Medication Ratio (Total)
PA EQR	Asthma in Younger Adults Admission Rate (Age 18-39 years) – Admission per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40+ years) - Admission per 100,000 Member Months
Comprehensive Diabetes Care	
HEDIS	Hemoglobin A1c (HbA1c) Testing
HEDIS	HbA1c Poor Control (>9.0%)
HEDIS	HbA1c Control (<8.0%)
HEDIS	HbA1c Good Control (<7.0%)
HEDIS	Retinal Eye Exam
HEDIS	Medical Attention for Nephropathy
HEDIS	Blood Pressure Controlled <140/90 mm Hg
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 18-64 years)
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 65+ years)
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Rate)
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age)
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 65 - 75 Years of Age)
Cardiovascular Care	
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack
HEDIS	Controlling High Blood Pressure
PA EQR	Heart Failure Admission Rate1 (Age 18-64 Years) per 100,000 member months
PA EQR	Heart Failure Admission Rate1 (Age 65+ Years) per 100,000 member months
PA EQR	Heart Failure Admission Rate1 (Total Age 18+ Years) per 100,000 member months
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21-75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 21-75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate
HEDIS	Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia
Utilization	
PA EQR	Reducing Potentially Preventable Readmissions
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 1 - 5 years)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 6 - 11 years)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 12 - 17 years)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)

Source	Measures
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 1 - 5 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 6 - 11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 12 - 17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)
HEDIS	Use of Opioids at High Dosage[2]
HEDIS	Use of Opioids from Multiple Provider (4 or more prescribers)
HEDIS	Use of Opioids From Multiple Providers- (4 or more pharmacies)
HEDIS	Use of Opioids From Multiple Providers - (4 or more prescribers & pharmacies)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (CLABSI)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - unavailable SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (CAUTI)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - unavailable SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (MRSA)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - unavailable SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (CDIFF)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - unavailable SIR
HEDIS	Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed Readmission Rate - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed Readmission Rate - 4+ Stays (Ages Total)

[2] A similar measure called Use of Opioids at High Doses was a PA Specific Administrative measure in 2017. This measure was retired in 2018 and replaced by the new HEDIS measure, Use of Opioids at High Dosage. No comparison is made between the new 2018 HEDIS Opioid measure and the retired 2017 PA Specific Administrative measure in this report.

Source	Measures
HEDIS	Plan All-Cause Readmissions (PCR): Observed Readmission Rate - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Expected Readmission Rate - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Expected Readmission Rate - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Expected Readmission Rate - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - Total Stays (Ages Total)

PA-Specific Performance Measure Selection and Descriptions

Several PA-specific performance measures were calculated by each MCO and validated by IPRO. In accordance with DHS direction, IPRO created the indicator specifications to resemble HEDIS® specifications. Measures previously developed and added as mandated by CMS for children in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) and for adults in accordance with the Affordable Care Act (ACA) were continued as applicable to revised CMS specifications. Additionally, new measures were developed and added in 2018 as mandated in accordance with the ACA. For each indicator, the eligible population is identified by product line, age, enrollment, anchor date, and event/diagnosis. Administrative numerator positives are identified by date of service, diagnosis/procedure code criteria, as well as other specifications, as needed. Indicator rates are 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.

PA Specific Administrative Measures

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (New - 2018)

This performance measure assesses the percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – CHIPRA Core Set

DHS enhanced this measure using Behavioral Health (BH) encounter data contained in IPRO's encounter data warehouse. IPRO evaluated this measure using HEDIS 2018 Medicaid member level data submitted by the PH MCO.

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

Initiation Phase: The percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

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

Developmental Screening in the First Three Years of Life– CHIPRA Core Set

This performance measure assesses the percentage of children screened for risk of developmental, behav
ioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. Four rates, one for each group and a combined rate are to be calculated and reported for each numerator.

Follow-Up After Emergency Department Visit for Mental illness or Alcohol and Other Drug Abuse or Dependence (New - 2018)

This performance measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of mental illness or alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for mental illness or AOD. Four rates are reported:

Mental Illness

- 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)
- 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).

Alcohol and Other Drug Abuse or Dependence

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

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

Annual Dental Visits For Enrollees with Developmental Disabilities

This performance measure assesses the percentage of enrollees with a developmental disability age two through 20 years of age, who were continuously enrolled and had at least one dental visit during the measurement year. This indicator utilizes the HEDIS 2018 measure Annual Dental Visit (ADV).

Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk – CHIPRA Core Set

This performance measure assesses the percentage of enrolled children ages 6-9 years at elevated risk of dental caries who received a sealant on a permanent first molar tooth within the measurement year.

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

Contraceptive Care for All Women Ages 15-44 - CMS Core measure – New 2018

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

Contraceptive Care for Postpartum Women Ages 15-44 - CMS Core measure– New 2018

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

Frequency of Ongoing Prenatal Care

This performance measure assesses the percentage of pregnant enrollees who delivered on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal care visits:

- ≥ than 61 percent of expected visits
- ≥ than 81 percent of expected visits

Cesarean Rate for Nulliparous Singleton Vertex – CHIPRA Core Set

This performance measure assesses Cesarean Rate for low-risk first birth women [aka NSV CS rate: nulliparous, term, singleton, vertex].

Percent of Live Births Weighing Less than 2,500 Grams – CHIPRA Core Set

This performance measure is event-driven and identifies all live births during the measurement year in order to assess the number of live births that weighed less than 2,500 grams as a percent of the number of live births.

Elective Delivery – Adult Core Set

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

Asthma in Younger Adults Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for asthma in adults ages 18 to 39 years per 100,000 Medicaid member months.

Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid members 40 years and older. Three age groups will be reported: ages 40-64 years and age 65 years and older, and 40+ years.

Diabetes Short-Term Complications Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for diabetes short-term complications (ketoacidosis, hyperosmolarity or coma) in adults 18 years and older per 100,000 Medicaid member months. Two age groups will be reported: ages 18-64 years and age 65 years and older.

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (New - 2018)

This performance measure assess the percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) in poor control (>9.0%)

Heart Failure Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for heart failure in adults 18 years and older per 100,000 Medicaid member months. Three age groups are reported: ages 18-64 years, ages 65 years and older and total age.

Reducing Potentially Preventable Readmissions

This performance measure assesses the percentage of inpatient acute care discharges with subsequent readmission to inpatient acute care within 30 days of the initial inpatient acute discharge. This measure utilized the 2018 HEDIS Inpatient Utilization – General Hospital/Acute Care measure methodology to identify inpatient acute care discharges. For this measure, a lower rate indicates better performance.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia – Adult Core Set

The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. Members in hospice are excluded from eligible population.

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

PA Specific Hybrid Measures

Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit

This performance measure assesses the percentage of pregnant enrollees who were:

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

This performance measure uses components of the HEDIS 2018 Prenatal and Postpartum Care Measure.

Perinatal Depression Screening

This performance measure assesses the percentage of enrollees who were:

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

This performance measure uses components of the HEDIS 2018 Prenatal and Postpartum Care Measure.

Maternity Risk Factor Assessment

This performance measure assesses, for each of the following risk categories, the percentage of pregnant enrollees who were:

1. Screened for alcohol use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
2. Screened for illicit drug use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
3. Screened for prescribed or over-the-counter drug use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
4. Screened for intimate partner violence during the time frame of one of their first two prenatal visits (CHIPRA indicator).

This performance measure uses components of the HEDIS 2018 Prenatal and Postpartum Care Measure.

Behavioral Health Risk Assessment– CHIPRA Core Set

This performance measure is a combination of the screening assessments for all risk factors identified by each of the CHIPRA indicators in the Perinatal Depression Screening (PDS), Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit (PSS), and Maternity Risk Factor Assessment (MRFA) measures.

This performance measure assesses the percentage of enrollees who were screened during the time frame of one of their first two prenatal visits for all of the following risk factors:

1. depression screening,
2. tobacco use screening,
3. alcohol use screening,
4. drug use screening (illicit and prescription, over the counter), and
5. intimate partner violence screening.

HEDIS Performance Measure Selection and Descriptions

Each MCO underwent a full HEDIS compliance audit in 2018. As indicated previously, performance on selected HEDIS measures is included in this year's EQR report. Development of HEDIS measures and the clinical rationale for their inclusion in the HEDIS measurement set can be found in HEDIS 2018, Volume 2 Narrative. The measurement year for HEDIS 2018 measures is 2017, as well as prior years for selected measures. Each year, DHS updates its requirements for the MCOs to be consistent with NCQA's requirement for the reporting year. MCOs are required to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the HEDIS Technical Specifications, Volume 2. In addition, DHS does not require the MCOs to produce the Chronic Conditions component of the CAHPS 5.0 – Child Survey.

Children and Adolescents' Access to Primary Care Practitioners

This measure assesses the percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

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

Adults' Access to Preventive/Ambulatory Health Services

This measure assesses the percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line. The following age groups are reported: 20-44, 45-64, and 65+

Adult Body Mass Index (BMI) Assessment

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

Well-Child Visits in the First 15 Months of Life

This measure assessed the percentage of enrollees who turned 15 months old during the measurement year, who were continuously enrolled from 31 days of age through 15 months of age who received six or more well-child visits with a PCP during their first 15 months of life.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This measure assessed the percentage of enrollees who were 3, 4, 5, or 6 years of age during the measurement year, who were continuously enrolled during the measurement year and received one or more well-child visits with a PCP during the measurement year.

Childhood Immunization Status

This measure assessed the percentage of children who turned two years of age in the measurement year who were continuously enrolled for the 12 months preceding their second birthday and who received one or both of two immunization combinations on or before their second birthday. Separate rate were calculated for each Combination. Combination 2 and 3 consists of the following immunizations:
(4) Diphtheria and Tetanus, and Pertussis Vaccine/Diphtheria and Tetanus (DTaP/DT)
(3) Injectable Polio Vaccine (IPV)
(1) Measles, Mumps, and Rubella (MMR)
(3) Haemophilius Influenza Type B (HiB)
(3) Hepatitis B (HepB)
(1) Chicken Pox (VZV)
(4) Pneumococcal Conjugate Vaccine – Combination 3 only

Adolescent Well-Care Visits

This measure assessed the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

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

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

Immunization for Adolescents (Combo 1)

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

Lead Screening in Children

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

Follow-up Care for Children Prescribed ADHD Medication

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

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

Annual Dental Visit

This measure assessed the percentage of children and adolescents between the ages of 2 and 20 years of age who were continuously enrolled in the MCO for the measurement year who had a dental visit during the measurement year.

Breast Cancer Screening

This measure assessed the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

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

Cervical Cancer Screening

This measure assessed the percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed every 3 years.
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Chlamydia Screening in Women

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

Non-Recommended Cervical Cancer Screening in Adolescent Females

This measure assessed the percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. For this measure, a lower rate indicates better performance.

Prenatal and Postpartum Care

This measure assessed the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Appropriate Testing for Children with Pharyngitis

This measure assessed the percentage of children 3–18 years of age who were 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).

Appropriate Treatment for Children with Upper Respiratory Infection

This measure assessed the percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This measure assessed the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

This measure assessed the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

Pharmacotherapy Management of COPD Exacerbation

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

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

Medication Management for People with Asthma - 75% Compliance

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

Asthma Medication Ratio – New 2018

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

Comprehensive Diabetes Care

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

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

Statin Therapy for Patients With Diabetes

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

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

Persistence of Beta-Blocker Treatment After a Heart Attack

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

Controlling High Blood Pressure

This measure assessed the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

For this measure, a single rate, the sum of all three groups, is reported.

Statin Therapy for Patients With Cardiovascular Disease

This measure assessed the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

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

Total rates for 1 and 2 are also reported.

Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia

This measure assessed the percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

This measure assessed the percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

This measure assessed the percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications. Age groups 1 -5, 6-11, 12-17 and total are reported.

For this measure a lower rate indicates better performance.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure assessed the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Age groups 1-5, 6-11, 12-17, and total years are reported.

Use of Opioids at High Dosage – New 2018

This measure assessed for members 18 years and older, the rate per 1,000 receiving prescription opioids for ≥15 days at a high dosage (average morphine equivalent dose [MED] >120 mg).

Note: A similar measure called Use of Opioids at High Doses was a PA Specific Administrative measure in 2017. This measure was retired in 2018 and replaced by the new HEDIS measure, Use of Opioids at High Dosage. No comparison is made between the new 2018 HEDIS Opioid measure and the retired 2017 PA Specific Administrative measure in this report.

Use of Opioids from Multiple Providers – NEW 2018

This measure assessed for members 18 years and older, the rate per 1,000 receiving prescription opioids for ≥15 days who received opioids from multiple providers. Three rates are reported:

1. **Multiple Prescribers:** The rate per 1,000 of members receiving prescriptions for opioids from four or more different prescribers during the measurement year
2. **Multiple Pharmacies:** The rate per 1,000 of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
3. **Multiple Prescribers and Multiple Pharmacies:** The rate per 1,000 of members receiving prescriptions for opioids from four or more different prescribers ***and*** four or more different pharmacies during the measurement year

Standardized Healthcare-Associated Infection Ratio – NEW 2018

This measure assessed hospital-reported standard infection ratios (SIR) for four different healthcare-associated infections (HAI), adjusted for the proportion of members discharged from each acute care hospital. The measure reports the percentage of total discharges from hospitals with a high, moderate, low or unavailable SIR, next to a total plan-weighted SIR for each of the following infections:

- *HAI-1:* Central line-associated blood stream infections (CLABSI)
- *HAI-2:* Catheter-associated urinary tract infections (CAUTI)
- *HAI-5:* Methicillin-resistant Staphylococcus aureus (MRSA) blood laboratory-identified events (bloodstream infections)
- *HAI-6:* Clostridium difficile laboratory-identified events (intestinal infections) (CDIFF)

Note: *A lower SIR indicates better performance. SIRs >1.0 indicate that more infections occurred than expected; SIRs <1.0 indicate fewer infections occurred than expected.*

Plan All-Cause Readmissions (PCR) – NEW 2018

The measure assessed for members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported for members with 1-3, 4+, and total index hospital stays in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator)
2. Count of 30-Day Readmissions (numerator)
3. Observed Readmission Rate
4. Expected Readmissions Rate
5. Observed to Expected Readmission Ratio

CAHPS® Survey

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

Implementation of PA-Specific Performance Measures and HEDIS Audit

The MCO successfully implemented all of the PA-specific measures for 2018 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures. As previously indicated, for three PA Birth-related performance measures IPRO utilized the MCO Birth files in addition to the 2018 Department of Health Birth File to identify the denominator, numerator and rate for the Birth-related measures.

IPRO validated the medical record abstraction of the three PA-specific hybrid measures consistent with the protocol used for a HEDIS audit. The validation process includes a MRR process evaluation and review of the MCO's MRR tools and instruction materials. This review ensures that the MCO's MRR process was executed as planned and the abstraction results are accurate. A random sample of 16 records from each selected indicator across the three measures was evaluated. The indicators were selected for validation based on preliminary rates observed upon the MCO's completion of abstraction. The MCO passed MRR Validation for the Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit, the Perinatal Depression Screening, and the Maternity Risk Factor Assessment measures.

In 2018 it was identified that 6 of 9 PH MCOs incorrectly excluded denied claims from the 2017 (MY 2016) Reducing Potentially Preventable Readmissions (RPR) rate. This affected the RPR rate reported in the 2017 EQR reports. Corrected 2017 (MY 2016) data files were resubmitted by affected MCOs. Revised RPR 2017 (MY 2016) rates are included in this report.

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

Findings

MCO results are presented in Tables 3.2 through 3.11. For each measure, the denominator, numerator, and measurement year rates with 95% upper and lower confidence intervals (95% CI) are presented. Confidence intervals are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% confidence interval indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly,

would fall within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the confidence interval 95 times, or 95% of the time.

Rates for both the measurement year and the previous year are presented, as available [i.e., 2018 (MY 2017) and 2017 (MY 2016)]. In addition, statistical comparisons are made between the 2018 and 2017 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 2018 rates to 2017 rates, statistically significant increases are indicated by "+", statistically significant decreases by "–" and no statistically significant change by "n.s.".

In addition to each individual MCO's rate, the MMC average for 2018 (MY 2017) is presented. The MMC average is a weighted average, which is an average that takes into account the proportional relevance of each MCO. Each table also presents the significance of difference between the plan's measurement year rate and the MMC average for the same year. For comparison of 2018 rates to MMC rates, the "+" symbol denotes that the plan rate exceeds the MMC rate; the "–" symbol denotes that the MMC rate exceeds the plan rate and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power, and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage point difference between two rates was statistically significant in many cases, although not meaningful. Hence, results corresponding to each table highlight only differences that are both statistically significant, and display at least a **3**-percentage point difference in observed rates. It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates may not yield statistical significance due to reduced power; if statistical significance is not achieved, results will not be highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, "NA" (Not Applicable) appears in the corresponding cells. However, "NA" (Not Available) also appears in the cells under the HEDIS 2018 percentile column for PA-specific measures that do not have HEDIS percentiles to compare.

The tables below 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 the rates as presented in the table.

Access to/Availability of Care

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

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
    - Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years) – 5.4 percentage points
    - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years) – 5.2 percentage points

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

Table 3.2: Access to Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12 24 months)	4,605	4,478	**97.2%**	96.8%	97.7%	97.2%	n.s.	96.0%	+	>= 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months 6 years)	19,452	17,448	**89.7%**	89.3%	90.1%	91.8%	-	88.4%	+	>= 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 7 11 years)	16,594	15,645	**94.3%**	93.9%	94.6%	94.1%	n.s.	92.6%	+	>= 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12 19 years)	23,290	21,747	**93.4%**	93.1%	93.7%	93.1%	n.s.	91.5%	+	>= 75th and < 90th percentile

HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20 44 years)	47,227	39,332	**83.3%**	82.9%	83.6%	84.3%	-	77.8%	+	>= 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45 64 years)	24,793	22,064	**89.0%**	88.6%	89.4%	90.2%	-	86.1%	+	>= 50th and < 75th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ years)	416	367	**88.2%**	85.0%	91.4%	90.1%	n.s.	83.0%	+	>= 50th and < 75th percentile
HEDIS	Adult BMI Assessment (Age 18 74 years)	147	139	**94.6%**	90.6%	98.6%	91.8%	n.s.	91.9%	n.s.	>= 75th and < 90th percentile
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 5)	15	9	**NA**	NA	NA	NA	NA	60.7%	NA	NA
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 6 to 11)	180	129	**71.7%**	64.8%	78.5%	NA	NA	72.7%	n.s.	NA
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)	233	158	**67.8%**	61.6%	74.0%	NA	NA	69.6%	n.s.	NA
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)	428	296	**69.2%**	64.7%	73.7%	NA	NA	70.6%	n.s.	NA

Well-Care Visits and Immunizations

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

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Well-Child Visits in the First 15 Months of Life (≥ 6 Visits) – 4.9 percentage points
  - Body Mass Index: Percentile (Total) – 4.7 percentage points

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

Table 3.3: Well-Care Visits and Immunizations

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	**Indicator**	**Denom**	**Num**	**Rate**	**Lower 95% Confidence Interval**	**Upper 95% Confidence Interval**	**2017 (MY2016) Rate**	**2018 Rate Compared to 2017**	**MMC**	**2018 Rate Compared to MMC**	**HEDIS 2018 Percentile**
HEDIS	Well Child Visits in the First 15 Months of Life (≥ 6 Visits)	342	256	**74.9%**	70.1%	79.6%	72.0%	n.s.	69.9%	+	>= 75th and < 90th percentile
HEDIS	Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (Age 3 to 6 years)	288	230	**79.9%**	75.1%	84.7%	78.7%	n.s.	77.6%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunizations Status (Combination 2)	411	313	**76.2%**	71.9%	80.4%	77.1%	n.s.	76.1%	n.s.	>= 50th and < 75th percentile
HEDIS	Childhood Immunizations Status (Combination 3)	411	301	**73.2%**	68.8%	77.6%	75.4%	n.s.	73.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Adolescent Well Care Visits (Age 12 to 21 Years)	407	247	**60.7%**	55.8%	65.6%	55.4%	n.s.	62.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Body Mass Index: Percentile (Age 3 11 years)	253	211	**83.4%**	78.6%	88.2%	84.3%	n.s.	78.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Body Mass Index: Percentile (Age 12 17 years)	142	115	**81.0%**	74.2%	87.8%	78.8%	n.s.	76.3%	n.s.	>= 50th and < 75th percentile
HEDIS	Body Mass Index: Percentile (Total)	395	326	**82.5%**	78.7%	86.4%	82.2%	n.s.	77.8%	+	>= 50th and < 75th percentile
HEDIS	Counseling for Nutrition (Age 3 11 years)	253	183	**72.3%**	66.6%	78.0%	69.1%	n.s.	74.4%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Nutrition (Age 12 17 years)	142	98	**69.0%**	61.1%	77.0%	63.8%	n.s.	71.7%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Nutrition (Total)	395	281	**71.1%**	66.5%	75.7%	67.0%	n.s.	73.4%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Age 3 11 years)	253	165	**65.2%**	59.2%	71.3%	60.6%	n.s.	65.4%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Age 12 17 years)	142	98	**69.0%**	61.1%	77.0%	64.4%	n.s.	68.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Total)	395	263	**66.6%**	61.8%	71.4%	62.1%	n.s.	66.5%	n.s.	>= 50th and < 75th percentile

HEDIS	Immunization for Adolescents (Combo 1)	411	355	**86.4%**	82.9%	89.8%	84.9%	n.s.	85.9%	n.s.	>= 75th and < 90th percentile

EPSDT: Screenings and Follow-up

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

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Developmental Screening in the First Three Years of Life - Total – 6.4 percentage points
  - Developmental Screening in the First Three Years of Life - 1 year – 9.9 percentage points
  - Developmental Screening in the First Three Years of Life - 2 years – 4.6 percentage points
  - Developmental Screening in the First Three Years of Life - 3 years – 4.4 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days) – 20.1 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days) – 14.2 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase – 7.6 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase – 5.8 percentage points

Table 3.4: EPSDT: Screenings and Follow-up

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Lead Screening in Children (Age 2 years)	411	336	**81.8%**	77.9%	85.6%	84.9%	n.s.	80.3%	n.s.	>= 75th and < 90th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Initiation Phase	1,100	432	**39.3%**	36.3%	42.2%	36.7%	n.s.	40.5%	n.s.	>= 25th and < 50th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Continuation Phase	386	145	**37.6%**	32.6%	42.5%	40.0%	n.s.	45.2%	-	< 10th percentile
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase	1,100	452	**41.1%**	38.1%	44.0%	38.4%	n.s.	41.2%	n.s.	NA
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase	375	160	**42.7%**	37.5%	47.8%	44.3%	n.s.	48.5%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life Total	11,074	6,873	**62.1%**	61.2%	63.0%	65.8%	-	55.7%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life 1 year	3,763	2,264	**60.2%**	58.6%	61.7%	62.4%	-	50.3%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life 2 years	3,657	2,331	**63.7%**	62.2%	65.3%	67.8%	-	59.1%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life 3 years	3,654	2,278	**62.3%**	60.8%	63.9%	67.3%	-	57.9%	+	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for mental illness, follow up within 7 days)	83	46	**55.4%**	44.1%	66.7%	NA	NA	35.3%	+	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for mental illness, follow up within 30 days)	83	53	**63.9%**	52.9%	74.8%	NA	NA	49.7%	+	NA

PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for AOD abuse or dependence, follow up within 7 days)	1,051	151	**14.4%**	12.2%	16.5%	NA	NA	15.3%	n.s.	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for AOD abuse or dependence, follow up within 30 days)	1,051	233	**22.2%**	19.6%	24.7%	NA	NA	23.2%	n.s.	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for AOD abuse or dependence, follow up within 30 days)	0	0	**NA**	NA	NA	NA	NA	31.8%	NA	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for mental illness, follow up within 30 days)	0	0	**NA**	NA	NA	NA	NA	NA	NA	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for AOD abuse or dependence, follow up within 7 days)	0	0	**NA**	NA	NA	NA	NA	13.6%	NA	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for mental illness, follow up within 7 days)	0	0	**NA**	NA	NA	NA	NA	NA	NA	NA

Dental Care for Children and Adults

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

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk – 14.1 percentage points
  - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk (Dental Enhanced) – 12.8 percentage points

Opportunities for improvement are identified for Dental Care for Children and Adults performance measures.

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Annual Dental Visit (Age 2–20 years) – 5.1 percentage points
  - Annual Dental Visits for Members with Developmental Disabilities (Age 2-20years) – 6.8 percentage points

Table 3.5: EPSDT: Dental Care for Children and Adults

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Annual Dental Visit (Age 2 20 years)	69,491	40,200	**57.8%**	57.5%	58.2%	57.7%	n.s.	63.0%	-	>= 50th and < 75th percentile
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2 20years)	2,668	1,485	**55.7%**	53.8%	57.6%	57.4%	n.s.	62.5%	-	NA
PA EQR	Dental Sealants for 6 9 Year Of Children At Elevated Caries Risk	8,665	3,331	**38.4%**	37.4%	39.5%	18.8%	+	24.4%	+	NA
PA EQR	Dental Sealants for 6 9 Year Of Children At Elevated Caries Risk (Dental Enhanced)	9,186	3,502	**38.1%**	37.1%	39.1%	17.7%	+	25.3%	+	NA

Women's Health

No strengths are identified for Women's Health performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Chlamydia Screening in Women (Total) – 9.3 percentage points
  - Chlamydia Screening in Women (Age 16-20 years) – 9.7 percentage points
  - Chlamydia Screening in Women (Age 21-24 years) – 8.6 percentage points
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20) – 5.7 percentage points
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44) – 3.2 percentage points
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44) – 4.5 percentage points

Table 3.6: Women's Health

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Breast Cancer Screening (Age 50 74 years)	6,313	3,719	**58.9%**	57.7%	60.1%	61.4%	-	58.4%	n.s.	>= 50th and < 75th percentile
HEDIS	Cervical Cancer Screening (Age 21 64 years)	380	229	**60.3%**	55.2%	65.3%	64.5%	n.s.	60.8%	n.s.	>= 50th and < 75th percentile
HEDIS	Chlamydia Screening in Women (Total)	7,982	4,088	**51.2%**	50.1%	52.3%	48.6%	+	60.6%	-	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Age 16 20 years)	4,400	2,076	**47.2%**	45.7%	48.7%	43.8%	+	56.9%	-	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Age 21 24 years)	3,582	2,012	**56.2%**	54.5%	57.8%	54.4%	n.s.	64.8%	-	>= 10th and < 25th percentile
HEDIS	Non Recommended Cervical Cancer Screening in Adolescent Females	7,551	168	**2.2%**	1.9%	2.6%	3.1%	-	0.9%	+	>= 10th and < 25th percentile
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)	8,972	2,421	**27.0%**	26.1%	27.9%	NA	NA	28.5%	-	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)	8,972	292	**3.3%**	2.9%	3.6%	NA	NA	5.0%	-	NA
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)	27,032	5,943	**22.0%**	21.5%	22.5%	NA	NA	25.0%	-	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)	27,032	1,347	**5.0%**	4.7%	5.2%	NA	NA	6.4%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 15 to 20)	386	31	**8.0%**	5.2%	10.9%	NA	NA	7.6%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 15 to 20)	386	140	**36.3%**	31.3%	41.2%	NA	NA	37.7%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 3 days (Ages 15 to 20)	386	5	**1.3%**	0.0%	2.6%	NA	NA	3.3%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 60 days (Ages 15 to 20)	386	31	**8.0%**	5.2%	10.9%	NA	NA	13.7%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 21 to 44)	3,155	447	**14.2%**	12.9%	15.4%	NA	NA	13.8%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 21 to 44)	3,155	1,141	**36.2%**	34.5%	37.9%	NA	NA	39.3%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 3 days (Ages 21 to 44)	3,155	17	**0.5%**	0.3%	0.8%	NA	NA	2.1%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 60 days (Ages 21 to 44)	3,155	193	**6.1%**	5.3%	7.0%	NA	NA	10.6%	-	NA

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

Obstetric and Neonatal Care

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

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - ≥ 61% of Expected Prenatal Care Visits Received – 6.7 percentage points
  - ≥ 81% of Expected Prenatal Care Visits Received – 8.5 percentage points
  - Prenatal Screening for Smoking – 7.0 percentage points
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 5.7 percentage points
  - Prenatal Screening for Environmental Tobacco Smoke Exposure – 6.4 percentage points
  - Prenatal Smoking Cessation – 6.0 percentage points
  - Prenatal Screening for Depression – 12.3 percentage points
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 13.1 percentage points
  - Postpartum Screening for Depression – 10.9 percentage points
  - Prenatal Screening for Alcohol use – 12.8 percentage points
  - Prenatal Screening for Illicit drug use – 16.7 percentage points
  - Prenatal Screening for Prescribed or over-the-counter drug use – 12.7 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Prenatal Counseling for Depression – 11.7 percentage points

Table 3.7: Obstetric and Neonatal Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
PA EQR	Frequency of Ongoing Prenatal Care Greater than or Equal to 61% of Expected Prenatal Care Visits Received	411	375	**91.2%**	88.4%	94.1%	89.5%	n.s.	84.6%	+	NA
PA EQR	Frequency of Ongoing Prenatal Care Greater than or Equal to 81% of Expected Prenatal Care Visits Received	411	325	**79.1%**	75.0%	83.1%	73.0%	+	70.6%	+	NA
HEDIS	Prenatal and Postpartum Care Timeliness of Prenatal Care	411	356	**86.6%**	83.2%	90.0%	90.5%	n.s.	86.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Prenatal and Postpartum Care Postpartum Care	411	289	**70.3%**	65.8%	74.9%	65.9%	n.s.	67.7%	n.s.	>= 75th and < 90th percentile
PA EQR	Prenatal Screening for Smoking	404	363	**89.9%**	86.8%	92.9%	90.4%	n.s.	82.8%	+	NA
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	404	355	**87.9%**	84.6%	91.2%	85.7%	n.s.	82.2%	+	NA
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure	404	214	**53.0%**	48.0%	58.0%	38.7%	+	46.5%	+	NA
PA EQR	Prenatal Counseling for Smoking	118	104	**88.1%**	81.9%	94.4%	80.8%	n.s.	86.1%	n.s.	NA
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure	73	57	**78.1%**	67.9%	88.3%	69.2%	n.s.	78.5%	n.s.	NA
PA EQR	Prenatal Smoking Cessation	119	19	**16.0%**	9.0%	23.0%	5.3%	+	10.0%	+	NA
PA EQR	Prenatal Screening for Depression	387	328	**84.8%**	81.0%	88.5%	78.6%	+	72.5%	+	NA
PA EQR	Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	387	303	**78.3%**	74.1%	82.5%	72.2%	+	65.2%	+	NA
PA EQR	Prenatal Screening Positive for Depression	328	71	**21.6%**	17.0%	26.3%	19.4%	n.s.	20.2%	n.s.	NA
PA EQR	Prental Counseling for Depression	71	44	**62.0%**	50.0%	74.0%	NA	NA	73.7%	-	NA
PA EQR	Postpartum Screening for Depression	267	225	**84.3%**	79.7%	88.8%	88.1%	n.s.	73.4%	+	NA
PA EQR	Postpartum Screening Positive for Depression	225	42	**18.7%**	13.4%	24.0%	16.8%	n.s.	15.2%	n.s.	NA
PA EQR	Postpartum Counseling for Depression	42	32	**76.2%**	62.1%	90.3%	74.3%	n.s.	87.3%	n.s.	NA
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	880	194	**22.0%**	19.2%	24.8%	22.9%	n.s.	23.6%	n.s.	NA

PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	4,053	290	**7.2%**	6.3%	8.0%	8.0%	n.s.	9.9%	-	NA
PA EQR	Prenatal Screening for Alcohol use	404	371	**91.8%**	89.0%	94.6%	91.4%	n.s.	79.1%	+	NA
PA EQR	Prenatal Screening for Illicit drug use	404	387	**95.8%**	93.7%	97.9%	91.9%	+	79.0%	+	NA
PA EQR	Prenatal Screening for Prescribed or over the counter drug use	404	389	**96.3%**	94.3%	98.3%	95.3%	n.s.	83.6%	+	NA
PA EQR	Prenatal Screening for Intimate partner violence	404	221	**54.7%**	49.7%	59.7%	68.2%	-	55.9%	n.s.	NA
PA EQR	Prenatal Screening for Behavioral Health Risk Assessment	387	154	**39.8%**	34.8%	44.8%	46.4%	n.s.	44.3%	n.s.	NA
PA EQR	Elective Delivery	980	32	**3.3%**	2.1%	4.4%	26.4%	-	4.7%	-	NA

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

Respiratory Conditions

Strengths are identified for the following Respiratory Conditions performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid – 4.3 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Age 5-11 years) – 4.5 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years) – 3.4 percentage points
  - Asthma Medication Ratio (5-11 years) – 8.3 percentage points
  - Asthma Medication Ratio (12-18 years) – 4.8 percentage points
  - Asthma Medication Ratio (19-50 years) – 3.8 percentage points
  - Asthma Medication Ratio (Total) – 3.8 percentage points
  - Asthma in Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months – 3.49 admissions per 100,000 member months

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months – 177.31 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 – 137.69 admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months – 177.04 admissions per 100,000 member months

Table 3.8: Respiratory Conditions

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Appropriate Testing for Children with Pharyngitis	4,465	3,761	**84.2%**	83.2%	85.3%	81.3%	+	82.9%	+	>= 50th and < 75th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection	4,900	314	**93.6%**	92.9%	94.3%	92.2%	+	91.1%	+	>= 50th and < 75th percentile
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	1,572	956	**39.2%**	36.7%	41.6%	34.0%	+	36.4%	+	>= 75th and < 90th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	501	153	**30.5%**	26.4%	34.7%	31.5%	n.s.	29.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	752	596	**79.3%**	76.3%	82.2%	66.9%	+	74.9%	+	>= 75th and < 90th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	752	646	**85.9%**	83.4%	88.5%	83.0%	n.s.	85.2%	n.s.	>= 50th and < 75th percentile

HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5 11 years)	616	262	**42.5%**	38.5%	46.5%	44.1%	n.s.	38.1%	+	>= 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 12 18 years)	642	273	**42.5%**	38.6%	46.4%	42.0%	n.s.	40.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 19 50 years)	1,106	544	**49.2%**	46.2%	52.2%	51.9%	n.s.	47.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 51 64 years)	298	195	**65.4%**	59.9%	71.0%	60.7%	n.s.	61.8%	n.s.	>= 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Total Age 5 64 years)	2,662	1,274	**47.9%**	45.9%	49.8%	47.5%	n.s.	44.5%	+	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (5 11 years)	660	531	**80.5%**	77.4%	83.6%	84.6%	-	72.1%	+	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (12 18 years)	739	537	**72.7%**	69.4%	75.9%	71.5%	n.s.	67.9%	+	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (19 50 years)	1,426	877	**61.5%**	58.9%	64.1%	57.5%	+	57.8%	+	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (51 64 years)	418	268	**64.1%**	59.4%	68.8%	60.3%	n.s.	61.2%	n.s.	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (Total)	3,243	2,213	**68.2%**	66.6%	69.9%	68.4%	n.s.	64.5%	+	>= 75th and < 90th percentile
PA EQR	Asthma in Younger Adults Admission Rate (Age 18 39 years) per 100,000 member months	731,131	28	**3.8**	2.4	5.2	4.8	n.s.	7.3	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months	472,037	1,283	**271.8**	256.9	286.7	NA	NA	94.5	+	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months	6,213	12	**193.1**	83.9	302.4	NA	NA	55.5	+	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months	478,250	1,295	**270.8**	256.0	285.5	53.1	+	93.7	+	NA

[1] Per NCQA, a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).
[2] Per NCQA, a higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).
[3] For the Adult Admission Rate measures, lower rates indicate better performance.

Comprehensive Diabetes Care

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

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Retinal Eye Exam – 5.8 percentage points
  - Blood Pressure Controlled <140/90 mm Hg – 12.9 percentage points
  - Statin Therapy for Patients With Diabetes: Received Statin Therapy – 4.5 percentage points
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age) – 9.8 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Statin Therapy for Patients With Diabetes: Statin Adherence 80% – 3.9 percentage points
  - Diabetes Short-Term Complications Admission Rate (Age 65+ years) per 100,000 member months – 14.25 admissions per 100,000 member months

Table 3.9: Comprehensive Diabetes Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Hemoglobin A1c (HbA1c) Testing	548	472	**86.1%**	83.1%	89.1%	85.3%	n.s.	87.2%	n.s.	>= 25th and < 50th percentile
HEDIS	HbA1c Poor Control (>9.0%)	548	177	**32.3%**	28.3%	36.3%	34.5%	n.s.	34.7%	n.s.	>= 75th and < 90th percentile
HEDIS	HbA1c Control (<8.0%)	548	304	**55.5%**	51.2%	59.7%	51.3%	n.s.	52.9%	n.s.	>= 75th and < 90th percentile
HEDIS	HbA1c Good Control (<7.0%)	418	162	**38.8%**	34.0%	43.5%	35.3%	n.s.	37.8%	n.s.	>= 50th and < 75th percentile
HEDIS	Retinal Eye Exam	548	355	**64.8%**	60.7%	68.9%	64.2%	n.s.	59.0%	+	>= 75th and < 90th percentile
HEDIS	Medical Attention for Nephropathy	548	488	**89.1%**	86.3%	91.8%	87.4%	n.s.	89.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Blood Pressure Controlled <140/90 mm Hg	548	450	**82.1%**	78.8%	85.4%	79.0%	n.s.	69.2%	+	>= 90th percentile
PA EQR	Diabetes Short Term Complications Admission Rate (Age 18 64 years) per 100,000 member months	1,203,168	158	**13.1**	11.1	15.2	14.4	n.s.	14.7	n.s.	NA
PA EQR	Diabetes Short Term Complications Admission Rate (Age 65+ years) per 100,000 member months	6,213	1	**16.1**	0.0	47.6	0.0	n.s.	1.8	+	NA
PA EQR	Diabetes Short Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months	1,209,381	159	**13.1**	11.1	15.2	14.3	n.s.	14.6	n.s.	NA
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy	3,470	2,247	**64.8%**	63.2%	66.4%	64.9%	n.s.	60.3%	+	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%	2,247	1,404	**62.5%**	60.5%	64.5%	66.3%	-	66.4%	-	>= 50th and < 75th percentile
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 64 Years of Age)	608	590	**97.0%**	95.6%	98.5%	NA	NA	87.2%	+	NA
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 65 75 Years of Age)	0	0	**NA**	NA	NA	NA	NA	86.4%	NA	NA

[1] For HbA1c Poor Control, lower rates indicate better performance.
[2] For the Adult Admission Rate measures, lower rates indicate better performance

Cardiovascular Care

Strengths are identified for the following Cardiovascular Care performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Controlling High Blood Pressure (Total Rate) – 6.1 percentage points
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21-75 years (Male) – 4.3 percentage points
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female) – 5.1 percentage points
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate – 4.7 percentage points
  - Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months – 5.30 admissions per 100,000 member months
  - Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months – 5.51 admissions per 100,000 member months

Opportunities for improvement are identified for Cardiovascular Care performance measures

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate – 3.3 percentage points

Table 3.10: Cardiovascular Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack	126	107	**84.9%**	78.3%	91.6%	88.8%	n.s.	85.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	342	241	**70.5%**	65.5%	75.4%	72.0%	n.s.	64.3%	+	>= 75th and < 90th percentile
PA EQR	Heart Failure Admission Rate (Age 18 64 years) per 100,000 member months	1,203,168	169	**14.0**	11.9	16.2	14.6	n.s.	19.4	-	NA
PA EQR	Heart Failure Admission Rate (Age 65+ years) per 100,000 member months	6,213	3	**48.3**	0.0	102.9	75.8	n.s.	70.2	n.s.	NA
PA EQR	Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months	1,209,381	172	**14.2**	12.1	16.3	14.9	n.s.	19.7	-	NA
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21 75 years (Male)	655	547	**83.5%**	80.6%	86.4%	84.4%	n.s.	79.2%	+	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40 75 years (Female)	524	424	**80.9%**	77.5%	84.4%	80.2%	n.s.	75.8%	+	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate	1,179	971	**82.4%**	80.1%	84.6%	82.5%	n.s.	77.7%	+	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% 21 75 years (Male)	547	360	**65.8%**	61.7%	69.9%	68.6%	n.s.	69.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% 40 75 years (Female)	424	288	**67.9%**	63.4%	72.5%	70.1%	n.s.	70.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% Total Rate	971	648	**66.7%**	63.7%	69.8%	69.3%	n.s.	70.0%	-	>= 50th and < 75th percentile
HEDIS	Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia	22	19	**NA**	NA	NA	NA	NA	78.1%	NA	NA

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

Utilization

Strengths are identified for the following Utilization performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia – 5.2 percentage points
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced) – 7.0 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 6 - 11 years – 11.7 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 12 - 17 years – 7.6 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Total Rate – 9.2 percentage points
  - Use of Opioids at High Dosage – 15.9 per 1000
  - Use of Opioids From Multiple Providers (4 or more pharmacies) – 53.3 per 1000
  - Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies) – 9.6 per 1000

Opportunities for improvement are identified for Utilization performance measures

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Use of Opioids from Multiple Providers (4 or more prescribers) – 15.7 per 1000

Table 3.11: Utilization

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
PA EQR	Reducing Potentially Preventable Readmissions	10,926	1,049	**9.6%**	9.0%	10.2%	10.64%	-	10.3%	-	NA
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	379	272	**71.8%**	67.1%	76.4%	70.62%	n.s.	66.6%	+	>= 90th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	816	620	**76.0%**	73.0%	79.0%	73.25%	n.s.	69.0%	+	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 1 5 years	13	0	**NA**	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 6 11 years	457	5	**1.1%**	0.0%	2.2%	2.05%	n.s.	0.8%	n.s.	>= 50th and < 75th percentile
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 12 17 years	843	23	**2.7%**	1.6%	3.9%	2.59%	NA	1.9%	n.s.	>= 25th and < 50th percentile
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Total Rate	1,313	28	**2.1%**	1.3%	3.0%	2.36%	n.s.	1.5%	n.s.	>= 25th and < 50th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 5 years	16	13	**NA**	NA	NA	NA	NA	NA	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 6 11 years	546	415	**76.0%**	72.3%	79.7%	58.87%	+	64.4%	+	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 12 17 years	998	699	**70.0%**	67.1%	72.9%	57.57%	+	62.4%	+	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Total Rate	1,560	1,127	**72.2%**	70.0%	74.5%	58.13%	+	63.1%	+	>= 90th percentile
HEDIS	Use of Opioids at High Dosage[3]	7,979	545	**68.3**	NA	NA	NA	NA	84.2	-	NA
HEDIS	Use of Opioids from Multiple Providers (4 or more proscribers)	9,500	1,703	**179.3**	NA	NA	NA	NA	163.5	-	NA
HEDIS	Use of Opioids From Multiple Providers (4 or more pharmacies)	9,500	407	**42.8**	NA	NA	NA	NA	96.1	-	NA
HEDIS	Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)	9,500	198	**20.8**	NA	NA	NA	NA	30.4	-	NA
HEDIS	Plan weighted SIR (CLABSI)			**0.73**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) high SIR			**0.20**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) moderate SIR			**0.05**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) low SIR			**0.59**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) unavailable SIR			**0.15**			NA	NA			NA
HEDIS	Plan weighted SIR (CAUTI)			**0.67**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) high SIR			**0.17**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) moderate SIR			**0.25**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) low SIR			**0.50**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) unavailable SIR			**0.09**			NA	NA			NA

[3] A similar measure called Use of Opioids at High Doses was a PA Specific Administrative measure in 2017. This measure was retired in 2018 and replaced by the new HEDIS measure, Use of Opioids at High Dosage. No comparison is made between the new 2018 HEDIS Opioid measure and the retired 2017 PA Specific Administrative measure in this report.

HEDIS	Plan weighted SIR (MRSA)			**0.44**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events high SIR			**0.12**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events moderate SIR			**0.04**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events low SIR			**0.68**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events unavailable SIR			**0.15**			NA	NA			NA
HEDIS	Plan weighted SIR (CDIFF)			**0.83**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) high SIR			**0.47**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) moderate SIR			**0.07**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) low SIR			**0.44**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) unavailable SIR			**0.02**			NA	NA			NA
		2018 (MY 2017)					**2018 (MY 2017) Rate Comparison**				
Indicator Source	**Indicator**		**Count**	**Rate**			**2017 (MY2016) Rate**	**2018 Rate Compared to 2017**			**HEDIS 2018 Percentile**
HEDIS	PCR: Count of Index Hospital Stays (IHS) 1 3 Stays (Ages Total)		4,313								NA
HEDIS	PCR: Count of Index Hospital Stays (IHS) 4+ Stays (Ages Total)		537								NA
HEDIS	PCR: Count of Index Hospital Stays (IHS) Total Stays (Ages Total)		4,850								NA
HEDIS	PCR: Count of 30 Day Readmissions 1 3 Stays (Ages Total)		334								NA
HEDIS	PCR: Count of 30 Day Readmissions 4+ Stays (Ages Total)		254								NA
HEDIS	PCR: Count of 30 Day Readmissions Total Stays (Ages Total)		588								NA
HEDIS	PCR: Observed Readmission Rate 1 3 Stays (Ages Total)			**7.7%**			NA	NA			NA
HEDIS	PCR: Observed Readmission Rate 4+ Stays (Ages Total)			**47.3%**			NA	NA			NA
HEDIS	PCR: Observed Readmission Rate Total Stays (Ages Total)			**12.1%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate 1 3 Stays (Ages Total)			**15.5%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate 4+ Stays (Ages Total)			**38.8%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate Total Stays (Ages Total)			**18.1%**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio 1 3 Stays (Ages Total)			**0.50**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio 4+ Stays (Ages Total)			**1.22**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio Total Stays (Ages Total)			**0.67**			NA	NA			NA

[1] For the Reducing Potentially Preventable Readmissions measure, lower rates indicate better performance.
[2] For the Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure, lower rates indicate better performance.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

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

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

2018 Adult CAHPS 5.0H Survey Results

Table 3.12: CAHPS 2018 Adult Survey Results

Survey Section/Measure Your Health Plan	2018 (MY 2017)	2018 Rate Compared to 2017	2017 (MY 2016)	2017 Rate Compared to 2016	2016 (MY 2015)	2018 MMC Weighted Average
Satisfaction with Adult's Health Plan (Rating of 8 to 10)	81.72%	▼	83.39%	▲	79.78%	79.32%
Getting Needed Information (Usually or Always)	82.95%	▼	86.21%	▼	86.99%	84.96%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	74.79%	▼	76.89%	▲	73.79%	74.94%
Appointment for Routine Care When Needed (Usually or Always)	81.74%	▲	79.67%	▼	82.29%	83.30%

▲▼ = Performance compared to prior years' rate
Shaded boxes reflect rates above the 2018 MMC Weighted Average.

2018 Child CAHPS 5.0H Survey Results

Table 3.13: CAHPS 2018 Child Survey Results

CAHPS Items Your Child's Health Plan	2018 (MY 2017)	2018 Rate Compared to 2017	2017 (MY 2016)	2017 Rate Compared to 2016	2016 (MY 2015)	2018 MMC Weighted Average
Satisfaction with Child's Health Plan (Rating of 8 to 10)	87.75%	▼	87.91%	▲	84.76%	86.50%
Getting Needed Information (Usually or Always)	87.23%	▲	87.16%	▲	73.53%	84.26%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	83.68%	▼	84.23%	▲	82.06%	84.69%
Appointment for Routine Care When Needed (Usually or Always)	92.06%	▲	88.50%	▼	91.13%	88.89%

▲▼ = Performance compared to prior years' rate
Shaded boxes reflect rates above the 2018 MMC Weighted Average.

IV: 2017 Opportunities for Improvement MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each PH MCO has addressed the opportunities for improvement made by IPRO in the 2017 EQR Technical Reports, which were distributed June 2018. The 2018 EQR is the tenth to include descriptions of current and proposed interventions from each PH MCO that address the 2017 recommendations.

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

- Follow-up actions that the MCO has taken through June 30, 2018 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 August 2018, as well as any additional relevant documentation provided by GEI.

Table 4.1 presents GEI's responses to opportunities for improvement cited by IPRO in the 2017 EQR Technical Report, detailing current and proposed interventions.

Table 4.1: Current and Proposed Interventions

Reference Number: GEI 2017.01: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Counseling for Nutrition (Age 3-11 years, 12-17, & Total)
Follow Up Actions Taken Through 06/30/2018: Educational documents for providers, including coding to satisfy HEDIS. Additional educational resources added for providers that use EMR. Expected outcomes are a 4-5% increase in the HEDIS rate for Counseling for Nutrition.
Future Actions Planned: Continued provider education through newsletters, Member Health Alerts, EMR and Bright Futures handout. Add WCCN and WCCP to Member Health Alerts for providers.
Reference Number: GEI 2017.02: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase
Follow Up Actions Taken Through 06/30/2018: Expanded embedded pediatric psychologist. Provider education regarding appropriate follow-up care. Letters mailed to members reminding the importance of follow up after new fill. Expected outcomes are 5% increase in Follow-up Care.
Future Actions Planned: Work with the Pharmacy Department for new starts to implement an alert for members to get in for a follow up and collaborate this information to the embedded pediatric psychologists. Work with Pharmacy Department for new starts to implement an alert for members to get in for a follow up. Provider education through newsletters and EMRs.
Reference Number: GEI 2017.03: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Annual Dental Visit (Age 2–20 years)
Follow Up Actions Taken Through 06/30/2018: Member incentive added for members age 6-9 and 19-21. [Geisinger Health Plan] [GHP] Wellness working with local Head Start locations to gather interest and need for future dental education and dental cleaning events. Avesis our dental vendor targets members starting at age 1 through "Connect the Dot" program they have. GMC Dental Residents are visiting local Head Start programs. Quality Champions are reaching out to members to members to schedule appointments.
Future Actions Planned: GHP has hired two Dental Medical Directors and two Public Health Dental Hygienists to discuss future strategies for education, oral assessments, fluoride application, dental cleanings and dental sealants. As their roles are being developed it is expected that it will include participation in the medical/dental partnerships of Healthy Teeth Healthy Children, GHP Wellness programs and other events in practice settings as permitted by their license. A transportation pilot program is being implemented to assist patients with their transportation needs. Expected outcomes is to increase 5% in Annual Dental Visits.
Reference Number: GEI 2017.04: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk

Follow Up Actions Taken Through 06/30/2018: Member incentive added for members age 6-9 and 19-21. GHP Wellness working with local Head Start locations to gather interest and need for future dental education and dental cleaning events. Avesis our dental vendor targets members starting at age 1 through "Connect the Dot" program they have. [
Geisinger Medical Center] [GMC] Dental Residents are visiting local Head Start programs. Quality Champions are reaching out to members to members to schedule appointments.

Future Actions Planned: GHP has hired two Dental Medical Directors and two Public Health Dental Hygienists to discuss future strategies for education, oral assessments, fluoride application, dental cleanings and dental sealants. As their roles are being developed it is expected that it will include participation in the medical/dental partnerships of Healthy Teeth Healthy Children, GHP Wellness programs and other events in practice settings as permitted by their license. A transportation pilot program is being implemented to assist patients with their transportation needs. Expected outcomes is to increase 5% in Annual Dental Visits.

Reference Number: GEI 2017.05: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk (Dental Enhanced)

Follow Up Actions Taken Through 06/30/2018: Member incentive added for members age 6-9 and 19-21. GHP Wellness working with local Head Start locations to gather interest and need for future dental education and dental cleaning events. Avesis our dental vendor targets members starting at age 1 through "Connect the Dot" program they have. GMC Dental Residents are visiting local Head Start programs. Quality Champions are reaching out to members to members to schedule appointments.

Future Actions Planned: GHP has hired two Dental Medical Directors and two Public Health Dental Hygienists to discuss future strategies for education, oral assessments, fluoride application, dental cleanings and dental sealants. As their roles are being developed it is expected that it will include participation in the medical/dental partnerships of Healthy Teeth Healthy Children, GHP Wellness programs and other events in practice settings as permitted by their license. A transportation pilot program is being implemented to assist patients with their transportation needs. Expected outcomes is to increase 5% in Annual Dental Visits.

Reference Number: GEI 2017.06: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Chlamydia Screening in Women (Age 1-20 years, 21-24, & Total)

Follow Up Actions Taken Through 06/30/2018: Coordination with the PA Department of Health and the CDC, who conducted on site educational sessions to 16 provider groups whose Chlamydia screening scores are behind the average for our service area. Expected outcome would be a 2% increase in Chlamydia Screening rates for HEDIS. The plan is also exploring the recommendation of universal screening protocols as part of quality Women's Health Care. Expected outcome is 5% increase in Chlamydia Screenings.

Future Actions Planned: To expand the universal screening to all CPSL sites and Non-Geisinger clinics. Provider education in Newsletters, brochures and Member Health Alerts.

Reference Number: GEI 2017.07: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Environmental Tobacco Smoke Exposure

Follow Up Actions Taken Through 06/30/2018: Quality LPNs reach out to newly identified pregnant members to scan for high risk. If the member is considered high risk, the member is sent to Case Management. Provider Education on screening for exposure to smoking.

Future Actions Planned: Provider education on screening members for environmental tobacco smoke exposure. Working with Case Management and Wellness for best practices. Expected outcome is 2% increase.

Reference Number: GEI 2017.08: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Elective Delivery

Follow Up Actions Taken Through 06/30/2018: Notification to Leadership of Women's Health, GHP physician leadership & GHP [Provider Network Management] [PNM] leadership regarding the increase in elective deliveries to advocate supports that lessen elective deliveries by providing data and education to provider groups.

Future Actions Planned: Provide data & education to providers through PNM liaison. Provider education in Newsletters, brochures and Member Health Alerts.

Reference Number: GEI 2017.09: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid

Follow Up Actions Taken Through 06/30/2018: A pharmacist reviews inpatient/ED charts and added any missing corticosteroid administrations.

Future Actions Planned: Continue with the pharmacist reviews.

Reference Number: GEI 2017.10: Of the four Adult CAHPS composite survey items reviewed, two decreased between

2017 (MY 2016) and 2016 (MY 2015). One item fell below the 2017 MMC weighted average.
Follow Up Actions Taken Through 06/30/2018: For CY2016, the MCO developed a 5-year plan that set several goals including having a Net Promoter Score in the Top 10% of all Businesses (not just health care) in the nation. This new member-centric strategy is designed to keep the member's health and the needs of the community at the forefront of all MCO decisions.
Future Actions Planned: Continue with the member-centric satisfaction strategy as well as improving access to routine primary care services for members.
Reference Number: GEI 2017.11: Of the four Child CAHPS composite survey items reviewed, two fell below the 2017 MMC weighted average. One item decreased in 2017 (MY 2016).
Follow Up Actions Taken Through 06/30/2018: For CY2016, the MCO developed a 5-year plan that set several goals including having a Net Promoter Score in the Top 10% of all Businesses (not just health care) in the nation. This new member-centric strategy is designed to keep the member's health and the needs of the community at the forefront of all MCO decisions.
Future Actions Planned: Continue with the member-centric satisfaction strategy as well as improving access to routine primary care services for members.

Root Cause Analysis and Action Plan

The 2018 EQR is the nineth year MCOs were required to prepare a Root Cause Analysis and Action Plan for measures on the HEDIS 2017 P4P Measure Matrix receiving either "D" or "F" ratings. Each P4P measure in categories "D" and "F" required that the MCO submit:

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

For the 2018 EQR, GEI was required to prepare a Root Cause Analysis and Action Plan for the following performance measures:

1. Comprehensive Diabetes Care: HbA1c Poor Control (Table 4.2)
2. Postpartum Care (Table 4.3)
3. Reducing Potentially Preventable Readmissions (Table 4.4)

GEI submitted an initial Root Cause Analysis and Action Plan in July 2018.

Table 4.2: RCA and Action Plan: Comprehensive Diabetes Care: HbA1c Poor Control

Instructions: For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance.

Managed Care Organization:	***Geisinger Health Plan***
Response Date:	**9/4/18**
Measure:	**Comprehensive Diabetes Care: HbA1c Poor Control**[4]
Reason for Root Cause Analysis:	**Comprehensive Diabetes Care: HbA1c Poor Control is statistically significantly lower/worse than 2016, but is not statistically significantly different from the 2017 MMC weighted average**
Goal Statement: Please specify goal(s) for measure	**Improvement in A1C control**
Part A: Identify Factors via Analysis	

[4] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance

Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year.

- If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average.
  and/or
- If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.

Factor categories	**Factors** **Enter "N/A" if a factor category does not apply**
Policies? (e.g., data systems, delivery systems, provider facilities)	Despite a robust EHR, 60-70% of our overall population being cared for is by non-Geisinger providers in which access to records is a challenge and/or EHR systems do no communicate. This makes it challenging for our clinical team to manage DM when A1C's and medications are not known and/or readily available.
Procedures? (e.g., payment/reimbursement, credentialing/collaboration)	Although collaboration among diabetes providers occur, there is a clear divide with regard to ADA recognition. With some of the changes noted for inpatient vs outpatient vs billable and non-billable providers; referrals for DM needs are typically routed to inpatient and/or billable providers rather than our clinical team. Often our clinical teams are pulled in for other issues or needs such for social determinants of heath.
People? (e.g., personnel, provider network, patients)	Geisinger has come to appreciate and recognizes the challenges that often impact patient care outside of the medical arena such as social determinants of health. Housing, transportation, food insecurity, and behavioral health needs often create barriers for pts with regard to their interest in seeking care and/or participating in their treatment plan.
Provisions? (e.g., screening tools, medical record forms, provider and enrollee educational materials)	Recognizing the need to reduce and/or eliminate SDOH barriers, Geisinger will work with the EHR as well as partner with community entities to better address such needs thus enabling the patient to focus on their clinical needs & improving their outcomes. Such system is not in place today.
Other? (specify)	Creating a system that interfaces with other applications/platforms while creating a more cohesive technological system or solution to monitor DM progress is essential. More importantly with regard to DM, placing a greater focus on prevention and prediabetes will be essential to meet the goal of improving our overall DM population.

Part B: Identify Actions – implemented and planned

For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2018

Actions Include those planned as well as already implemented. Actions should address factors contributing to poor performance compared to MMC average and/or previous year. **Add rows if needed.**	**Which factor(s) are addressed by this action?**	**Implementation Date** Indicate start date (month, year). Duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often?

Develop a prediabetes program. DM Prevention.	Policies	Jan 2018	Monthly review of caseload analysis/quarterly review of preDM outcomes
Partner with vendor organizations. Streamlined technology solutions.	Policies	In process-tentative go -live 9/2/18	Quarterly review of enrollment/engagement /sustainability outcomes
Create more cohesive/collaborative care team. Decrease fragmentation and assist with getting patient to the most appropriate resource given patients unique needs.	Procedures	Jan 2018	Monthly-Diabetes Care Transformation Committee Mtg.
Address SDOH Barrier Reduction/Elimination	Procedures	9/2/18	Monthly review of care gap closures
Increase referral criteria, outreach to larger population, not at DM goal.	People	1/2018	Monthly review of caseload analysis/quarterly review of DM outcomes
Factors not addressed by Actions Please list factors identified in Part A that are not addressed by the above actions and if known, the reason why.	N/A		

Table 4.3: RCA and Action Plan: Postpartum Care

Managed Care Organization:	***Geisinger Health Plan***
Response Date:	**9/4/18**
Measure:	**Postpartum Care**
Reason for Root Cause Analysis:	**Postpartum Care is statistically significantly lower/worse than 2016, but is not statistically significantly different from the 2017 MMC weighted average**
Goal Statement: Please specify goal(s) for measure	**The goal is to improve postpartum visits.**
Part A: Identify Factors via Analysis	
Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year. • If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average. and/or • If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.	

Factor categories	Factors Enter "N/A" if a factor category does not apply
Policies? (e.g., data systems, delivery systems, provider facilities)	Access to OB/GYN providers is not at full capacity. The lack of providers impacts the ability to schedule follow-up appointments. Open schedule availability is often beyond the time to meet HEDIS measures.
Procedures? (e.g., payment/reimbursement, credentialing/collaboration)	The Women's Health Special Needs unit had staffing changes during this period which included frontline staff and leadership therefore collaboration within clinics was low. Plans were not clearly made or well-planned. Connectivity between Inpatient and post discharge facility is poor.
People? (e.g., personnel, provider network, patients)	Patients do not recognize the importance of postpartum appointments especially if this is not their first child & if they are feeling well without complications. Postpartum appointments are not secured prior to discharge which inhibits the ability to schedule later.
Provisions? (e.g., screening tools, medical record forms, provider and enrollee educational materials)	Clinics tracking "no show" with no plan for follow-up. Incentives offered to members, but not communicated well to members or clinic areas therefore not being utilized effectively.
Other? (specify)	Transportation is an issue for many patients.

Part B: Identify Actions – implemented and planned

For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2018

Actions Include those planned as well as already implemented. Actions should address factors contributing to poor performance compared to MMC average and/or previous year. **Add rows if needed.**	**Which factor(s) are addressed by this action?**	**Implementation Date** Indicate start date (month, year). Duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often?
Access- additional OB/GYN providers added to Geisinger Health System. Scheduling calendars revamped with additional availability and Women's Health CM have relationship with schedulers to collaborate for appointments.	Policies	March 2017	Continual measurement of the Proactive HEDIS rate on a month by month basis
Women's Health team is embedded within the clinics in the North East, West and Central regions.	Procedures	March 2017	Continual measurement of the Proactive HEDIS rate on a month by month basis
Hired Peer Support Assistants to provide home visits, clinic visits & follow-up post-delivery & engage patients to schedule PP visit.	People	December 2017	Continual measurement of the Proactive HEDIS rate on a month by month basis

Daily collaboration staff huddle with team helps connectivity, sharing of information and communication for opportunities to improve care.	Procedures	January 2018	Continual measurement of the Proactive HEDIS rate on a month by month basis
Collaboration with area agencies to improve resources & care for mother and baby including baby supplies offered at postpartum visits to incent patients to make, attend appointments. (St Joseph Center- WB- to help members obtain baby related items.)	Procedures	August 2017	Continual measurement of the Proactive HEDIS rate on a month by month basis
Women's Health team with newly hired staff provide education to providers including physicians, frontline staff and management of clinics regarding our special needs unit & the services we provide to members. The clinics now provide "no show" lists for telephonic follow-up.	Provisions	December 2017	Continual measurement of the Proactive HEDIS rate on a month by month basis Clinic data on no show shared with frontline staff at monthly staff meeting
Transportation Pilot- GHP implemented 2 pilot programs to assist patients with transportation needs. By partnering with a community resources (Rabbit transit – 4ride) & other transportation providers in the area, members are provided resources for clinical & non-clinical appointments. Rides are being coordinated through the community health assistants (CHAs).	Other	April 2018	Continual measurement of the Proactive HEDIS rate on a month by month basis
Factors not addressed by Actions Please list factors identified in Part A that are not addressed by the above actions and if known, the reason why.			

Table 4.4: RCA and Action Plan: Reducing Potentially Preventable Readmissions

Managed Care Organization:	***Geisinger Health Plan***
Response Date:	**9/4/18**
Measure:	**Reducing Potentially Preventable Readmissions[5]**
Reason for Root Cause Analysis:	**Reducing Potentially Preventable Readmissions is statistically significantly lower/worse than 2016, and is statistically significantly lower/worse than the 2017 MMC weighted average**
Goal Statement: Please specify goal(s) for measure	**The goal is to stabilize or improve the preventable readmissions in this population.**
Part A: Identify Factors via Analysis	

[5] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance

Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year.

- If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average.

  and/or

- If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.

Factor categories	**Factors** **Enter "N/A" if a factor category does not apply**
Policies? (e.g., data systems, delivery systems, provider facilities)	Access for primary care providers is still not at full capacity. The lack of primary care providers impacts the ability to schedule follow up appointments. Also impacts the ability for patients to be seen with Acute issues.
Procedures? (e.g., payment/reimbursement, credentialing/collaboration)	Plans are not clearly made and discharge from Post-Acute setting is not well planned. Connectivity between the Inpatient facility and post discharge space are poor. Changes made to medications are not conveyed or clearly understood upon discharge. Difficulty assessing acuity of Heart Failure patients in their home environment. Connectivity of Care between the Specialist and Primary Care Physician is often disjointed.
People? (e.g., personnel, provider network, patients)	Patients do not recognize the importance of follow up visits. Discharge appointments are not secured prior to discharge.
Provisions? (e.g., screening tools, medical record forms, provider and enrollee educational materials)	Readmission Risk Scoring in Acute Setting is weak and poor predictor of Readmission Risk. Resources to assess patients on the weekend is poor.
Other? (specify)	Member transportation continues to be a problem with getting the patients who have been discharged back into their physicians. Rural areas have no public transportation and MATP is inadequate.

Part B: Identify Actions – implemented and planned

For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2018

Actions Include those planned as well as already implemented. Actions should address factors contributing to poor performance compared to MMC average and/or previous year.	**Which factor(s) are addressed by this action?**	**Implementation Date** Indicate start date (month, year). Duration and frequency (e.g.,	**Monitoring Plan** How will you know if this action is working? What will you measure and how often?

Add rows if needed.		Ongoing, Quarterly)	
Access- additional primary care providers being added to Geisinger Health System. Additional providers also being added to primary care offices that are strategic partners with Geisinger Health Plan.	Policies	January 2017	Continual measurement of the Proactive HEDIS Rate on a month by month basis
Inpatient and Outpatient Daily Collaboration Calls- Daily phone calls are set up to connect the Inpatient Case Managers and Outpatient Case Managers. The connectivity helps teams share information and communicate risks or opportunities for improved care.	Procedure	February 2018	Continual measurement of the Proactive HEDIS Rate on a month by month basis
Vests have been purchased that measure fluid in the chest of members with heart failure. Staff are trained to use the vests and collaborate in the care of these members.	Procedures	April 2017	Continual measurement of the Proactive HEDIS Rate on a month by month basis
The case management team is now embedded in some of the specialty clinics (pulmonary and cardiology in Danville, WB and Scranton), not only primary care.	Procedure	March 2017	Continual measurement of the Proactive HEDIS Rate on a month by month basis
Expansion of On-Call Case Management Services to support the patient through Transitions of Care.	Provisions	January 2018	Continual measurement of the Proactive HEDIS Rate on a month by month basis
Real-time readmission risk tool provides updates every 24-hours throughout patients stay, to wrap interventions around the discharge. Interventions are based on the readmission risk score. Developing measurement of member population/interventions based on risk score and outcomes – TBD.	Provisions	March 2017	Continual measurement of the Proactive HEDIS Rate on a month by month basis
The TOC Pilot utilizes specially trained RN Case Managers who focus only on TOC patients. These Case Managers support patients through the post discharge period and coordinate long term services as needed. The pilot program is being expanded to cover all regions of our coverage area.	Procedure	May 2017	Continual measurement of the Proactive HEDIS Rate on a month by month basis

Transportation Pilot- GHP implemented 2 pilot programs to assist patients with transportation needs. By partnering with a community resources, rabbit transit (4Ride) and other transportation providers in the area, members are provided resources for clinical and non-clinical appointments. Rides are being coordinated through the through the Community Health Assistants (CHA's).	Other	April 2018	Continual measurement of the Proactive HEDIS Rate on a month by month basis
Factors not addressed by Actions Please list factors identified in Part A that are not addressed by the above actions and if known, the reason why.			

V: 2018 Strengths and Opportunities for Improvement

The review of MCO's 2018 performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for Medicaid members served by this MCO.

Strengths

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

- For approximately one third of reported measures, the MCO's performance was statistically significantly above/better than the MMC weighted average in 2018 (MY 2017) on the following measures:
  - Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years)
  - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years)
  - Well-Child Visits in the First 15 Months of Life (≥ 6 Visits)
  - Body Mass Index: Percentile (Total)
  - Developmental Screening in the First Three Years of Life - Total
  - Developmental Screening in the First Three Years of Life - 1 year
  - Developmental Screening in the First Three Years of Life - 2 years
  - Developmental Screening in the First Three Years of Life - 3 years
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days)
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days)
  - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk
  - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk (Dental Enhanced)
  - ≥ 61% of Expected Prenatal Care Visits Received
  - ≥ 81% of Expected Prenatal Care Visits Received
  - Prenatal Screening for Smoking
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)
  - Prenatal Screening for Environmental Tobacco Smoke Exposure
  - Prenatal Smoking Cessation
  - Prenatal Screening for Depression
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
  - Postpartum Screening for Depression
  - Prenatal Screening for Alcohol use
  - Prenatal Screening for Illicit drug use
  - Prenatal Screening for Prescribed or over-the-counter drug use
  - Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid
  - Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)
  - Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years)
  - Asthma Medication Ratio (5-11 years)
  - Asthma Medication Ratio (12-18 years)
  - Asthma Medication Ratio (19-50 years)
  - Asthma Medication Ratio (Total)
  - Asthma in Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months
  - Retinal Eye Exam
  - Blood Pressure Controlled <140/90 mm Hg
  - Statin Therapy for Patients With Diabetes: Received Statin Therapy
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age)
  - Controlling High Blood Pressure (Total Rate)
  - Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months
  - Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months

- Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21-75 years (Male)
- Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female)
- Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 6 - 11 years
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 12 - 17 years
- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Total Rate
- Use of Opioids at High Dosage
- Use of Opioids From Multiple Providers (4 or more pharmacies)
- Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)

- The following strengths were noted in 2018 (MY 2017) for Adult and child CAHPS survey items:
  - Of the four Adult CAHPS composite survey items reviewed, one item was above the 2018 MMC Weighted average. One item increased in 2018 (MY 2017) as compared to 2017 (MY 2016).
  - Of the four Child CAHPS composite survey items reviewed, three items were above the 2018 MMC Weighted average. Two items increased in 2018 (MY 2017) as compared to 2017 (MY 2016).

Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC weighted average in 2018 (MY 2017) on the following measures:
  - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase
  - Annual Dental Visit (Age 2–20 years)
  - Annual Dental Visits for Members with Developmental Disabilities (Age 2-20years)
  - Chlamydia Screening in Women (Total)
  - Chlamydia Screening in Women (Age 16-20 years)
  - Chlamydia Screening in Women (Age 21-24 years)
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44)
  - Prenatal Counseling for Depression
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months
  - Diabetes Short-Term Complications Admission Rate (Age 65+ years) per 100,000 member months
  - Statin Therapy for Patients With Diabetes: Statin Adherence 80%
  - Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate
  - Use of Opioids from Multiple Providers (4 or more prescribers)

- The following opportunities were noted in 2018 (MY 2017) for Adult and Child CAHPS survey items:
  - Of the four Adult CAHPS composite survey items reviewed, three items fell below the 2018 MMC weighted average. Three items decreased between 2018 (MY 2017) and 2017 (MY 2016).
  - Of the four Child CAHPS composite survey items reviewed, one fell below the 2018 MMC weighted average. Two items decreased in 2018 (MY 2017).

Additional targeted opportunities for improvement are found in the MCO-specific HEDIS 2018 P4P Measure Matrix that follows.

P4P Measure Matrix Report Card 2018

The Pay-for-Performance (P4P) Matrix Report Card provides a comparative look at all measures in the Quality Performance Measures component of the "HealthChoices MCO Pay for Performance Program." Nine measures are Healthcare Effectiveness Data Information Set (HEDIS®) measures, and the remaining two are PA specific measures. The matrix:

1. Compares the Managed Care Organization's (MCO's) own P4P measure performance over the two most recent reporting years (2018 and 2017); and
2. Compares the MCO's 2018 P4P measure rates to the 2018 Medicaid Managed Care (MMC) Weighted Average.

The table is a three by three matrix. The horizontal comparison represents the MCO's current performance as compared to the most recent MMC weighted average. When comparing a MCO's rate to the MMC weighted average for each respective measure, the MCO rate can be either above average, average or below average. Whether or not a MCO performed above or below average is determined by whether or not that MCO's 95% confidence interval for the rate included the MMC Weighted Average for the specific indicator. 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 significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

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

The green box (A) indicates that performance is notable. The MCO's 2018 rate is statistically significantly above/better than the 2018 MMC weighted average and above/better than the MCO's 2017 rate.

The light green boxes (B) indicate either that the MCO's 2018 rate does not differ from the 2018 MMC weighted average and is above/better than 2017 or that the MCO's 2018 rate is statistically significantly above/better than the 2018 MMC weighted average but there is no change from the MCO's 2017 rate.

The yellow boxes (C) indicate that the MCO's 2018 rate is statistically significantly below/worse than the 2018 MMC weighted average and is above/better than the 2017 rate, or the MCO's 2018 rate does not differ from the 2018 MMC weighted average and there is no change from 2017, or the MCO's 2018 rate is statistically significantly above/better than the 2018 MMC weighted average but is lower/worse than the MCO's 2017 rate. No action is required although MCOs should identify continued opportunities for improvement.

The orange boxes (D) indicate either that the MCO's 2018 rate is statistically significantly lower/worse than the 2018 MMC weighted average and there is no change from 2017, or that the MCO's 2018 rate is not different than the 2018 MMC weighted average and is lower/worse than the MCO's 2017 rate. ***A root cause analysis and plan of action is therefore required.***

The red box (F) indicates that the MCO's 2018 rate is statistically significantly below/worse than the 2018 MMC weighted average and is below/worse than the MCO's 2017 rate. ***A root cause analysis and plan of action is therefore required.***

GEI Key Points

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

Measures that in 2018 are statistically significantly above/better than 2017, and are statistically significantly above/better than the 2018 MMC weighted average are:

- Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits
- Reducing Potentially Preventable Readmissions[6]

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

Measures that in 2018 did not statistically significantly change from 2017, but are statistically significantly above/better than the 2018 MMC weighted average are:

- Controlling High Blood Pressure
- Well-Child Visits in the First 15 Months of Life, 6 or more
- Medication Management for People With Asthma: 75% Total

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

Measures that in 2018 did not statistically significantly change from 2017, and are not statistically significantly different from the 2018 MMC weighted average are:

- Adolescent Well-Care Visits
- Comprehensive Diabetes Care: HbA1c Poor Control[7]
- Prenatal Care in the First Trimester
- Postpartum Care
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

▪ D - Root cause analysis and plan of action required

Measures that in 2018 did not statistically significantly change from 2017, but are statistically significantly lower/worse than the 2018 MMC weighted average are:

- Annual Dental Visit (Ages 2 – 20 years)

▪ F Root cause analysis and plan of action required

- No P4P measures fell into this comparison category.

[6] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance
[7] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance

Figure 5.1: P4P Measure Matrix

	Medicaid Managed Care Weighted Average Statistical Significance Comparison			
Year to Year Statistical Significance Comparison	**Trend**	**Below/Worse than Average**	**Average**	**Above/Better than Average**
	⬆	**C**	**B**	**A** Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Reducing Potentially Preventable Readmissions[8]
	No Change	**D** Annual Dental Visit (Ages 2 – 20 years)	**C** Adolescent Well-Care Visits Comprehensive Diabetes Care: HbA1c Poor Control[9] Prenatal Care in the First Trimester Postpartum Care Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	**B** Controlling High Blood Pressure Well-Child Visits in the First 15 Months of Life, 6 or more Medication Management for People With Asthma: 75% Total
	⬇	**F**	**D**	**C**

[8] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance
[9] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance

P4P performance measure rates for, 2015, 2016, 2017 and 2018 as applicable are displayed in Figure 5.2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

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

Table 5.1: P4P Measure Rates

Quality Performance Measure HEDIS®	HEDIS® 2015 Rate	HEDIS® 2016 Rate	HEDIS® 2017 Rate	HEDIS® 2018 Rate	HEDIS® 2018 MMC WA
Adolescent Well Care Visits (Age 12 21 Years)	60.3%	52.7% ▼	55.4% =	60.7% =	62.0%
Comprehensive Diabetes Care HbA1c Poor Control[10]	31.6%	28.8% =	34.5% ▲	32.3% =	34.7%
Controlling High Blood Pressure	66.9%	74.9% ▲	72.0% =	70.5% =	64.3%
Prenatal Care in the First Trimester	90.0%	90.0% =	90.5% =	86.6% =	86.6%
Postpartum Care		74.5% =	65.9% ▼	70.3% =	67.7%
Annual Dental Visits (Ages 2 20 years)[11]	56.0%	55.9% =	57.7% ▲	57.8% =	63.0%
Well Child Visits in the First 15 Months of Life, 6 or more		74.3% =	72.0% =	74.9% =	69.9%
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		73.5% NA	78.7% =	79.9% =	77.6%
Medication Management for People with Asthma: 75% Total		43.4% NA	47.5% ▲	47.9% =	44.5%
Quality Performance Measure PA	**2015 Rate**	**2016 Rate**	**2017 Rate**	**2018 Rate**	**2018 MMC WA**
Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received[12]	74.7%	73.5% =	73.0% =	79.1% ▲	70.6%
Reducing Potentially Preventable Readmissions[13]	9.7%	9.8% =	10.6% ▲	9.6% ▼	10.3%

[10] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
[11] In 2015, the Annual Dental Visit age range was 2-21 years
[12] Frequency of Ongoing Prenatal Care was collected as a first-year PA PM for 2018. Prior to 2018, this measure was collected and validated via HEDIS®.
[13] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance

VI: Summary of Activities

Structure and Operations Standards

- GEI was found to be fully compliant on Subparts C, D, and F. In subpart D, GEI was compliant on 10 categories and partially compliant on 1 category. Compliance review findings for GEI from RY 2017, RY 2016 and RY 2015 were used to make the determinations.

Performance Improvement Projects

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

Performance Measures

- GEI reported all HEDIS, PA-Specific and CAHPS Survey performance measures in 2018 for which the MCO had a sufficient denominator.

2017 Opportunities for Improvement MCO Response

- GEI provided a response to the opportunities for improvement issued in the 2017 annual technical report and a root cause analysis and action plan for those measures on the HEDIS 2017 P4P Measure Matrix receiving either "D" or "F" ratings

2018 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for GEI in 2018. A response will be required by the MCO for the noted opportunities for improvement in 2019.