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Geisinger Health Plan

External Quality Review

Annual Technical Report

April 2024

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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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I. Executive Summary

Purpose of Report

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

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

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

Scope of External Quality Review Activities Conducted

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

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

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

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

[1] prepaid inpatient health plan.

[2] prepaid ambulatory health plan.

[3] primary care case management.

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

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

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

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

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

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

Conclusions and Recommendations

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

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

II. Validation of Performance Improvement Projects

Objectives

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

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

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

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

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

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

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

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

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

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

Performance Improvement Project Topics

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

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

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

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

[4] Centers for Disease Control and Prevention (CDC). *2020 drug overdose death rates | Drug overdose | CDC Injury Center*. 2020 Drug Overdose Death Rates | Drug Overdose | CDC Injury Center.
[5] Agency for Healthcare Research and Quality (AHRQ). *Preventable emergency department visits*. Preventable Emergency Department Visits | Agency for Healthcare Research and Quality (ahrq.gov).
[6] SDoH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.
[7] CDC. (2022). *Social determinants of health at CDC*. Social Determinants of Health at CDC | About | CDC.
[8] Peters, Z. J., Santo, L., Davis, D., & DeFrances, C. J. (2023). Emergency Department Visits Related to Mental Health Disorders Among Adults, by Race and Hispanic Ethnicity: United States, 2018−2020. *National health statistics reports*, (181), 1–9. https://dx.doi.org/10.15620/cdc:123507.
[9] Penzenstadler, L., Gentil, L., Grenier, G., Khazaal, Y., & Fleury, M. J. (2020). Risk factors of hospitalization for any medical condition among patients with prior emergency department visits for mental health conditions. *BMC psychiatry*, *20*(1), 431. https://doi.org/10.1186/s12888-020-02835-2.

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points can be awarded for the two phases of the project noted above and combined to arrive at an overall score.

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

Table 1: Element Designation

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

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

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. As noted in **Table 2**, PIPs are also reviewed for the achievement of sustained improvement. Sustained improvement is assessed for the final year of a PIP, in this case, for MY 2022. The evaluation of the sustained improvement area has two review elements. These review elements have a total weight of 20%, for a possible maximum total of 20 points. To receive these points, the MCO must sustain improvement relative to baseline after achieving demonstrable improvement.

Table 2: Review Element Scoring Weights (Scoring Matrix)

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

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

Description of Data Obtained

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

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

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

- Use of Opioids at High Dosage (HDO) – This HEDIS measure "assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year."[10]
- Use of Opioids from Multiple Providers (UOP) – This HEDIS measure "assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥ 15 days during the measurement year from multiple providers. Three rates are reported:
  - Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year;
  - Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year; and
  - Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates)."[11]
- Risk of Continued Opioid Use (COU) – This HEDIS measure "assesses potentially high-risk opioid analgesic prescribing practices. The percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:
  - the percentage of members with at least 15 days of prescription opioids in a 30-day period; and
  - the percentage of members with at least 31 days of prescription opioids in a 62-day period."[12]
- Concurrent Use of Opioids and Benzodiazepines (COB-AD) – This CMS Adult Core Set measure "addresses two measurement areas: early opioid use and polypharmacy. This measure examines the percentage of beneficiaries with concurrent use of prescriptions for opioids and benzodiazepines, which is linked to an increased risk of morbidity and mortality."[13]
- Percent of Individuals with Opioid Use Disorder (OUD) Who Receive MAT (MCO-defined).
- Percentage of Adults > 18 Years with Pharmacotherapy for OUD Who Have (MCO-defined) at Least:
  - 90 Days; and

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

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

For the **"Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits"** PIP, DHS directed MCOs to define and collect ICP measures to address challenges with the previous PIP and give MCOs more control and increased ability to implement interventions that directly impact their populations. Rates for the ICP program are calculated by IPRO annually during the late fourth quarter, using encounters submitted by both the PH-MCOs and the BH-MCOs to PROMIS*e*™, Pennsylvania's claims processing, provider enrollment, and user management information system. Because the rates are produced late in the year, and because PH-MCOs do not have consistent access to BH encounter data, MCOs have experienced some difficulty implementing interventions to have a timely impact on their population. However, to keep the ICP population consistent, MCOs were provided with the methodology used in the program to define members with SPMI. Additionally, as discussions continued around the multiple factors that contribute to preventable admission and readmission, DHS requested that discussion of SDoH be included, as the conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes; differences in health are striking in communities with poor SDoH.

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

- Ambulatory Care (AMB): ED Utilization – This HEDIS measure summarizes utilization of ambulatory care in EDs.[14]
- Inpatient Utilization – General Hospital/Acute Care (IPU): Total Discharges – This HEDIS measure "summarizes utilization of acute inpatient care and services in the following categories:
  - maternity,
  - surgery,
  - medicine, and
  - total inpatient (the sum of Maternity, Surgery and Medicine)."[14]
- Plan All-Cause Readmissions (PCR): This HEDIS measure "assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge" for Medicaid members ages 18 to 64 years.[15]
- PH-MCOs were given the criteria used to define the SPMI population and will be collecting each of the following ICP measures using data from their own systems:
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (MCO-defined)
  - Emergency Room Utilization for Individuals with SPMI (MCO-defined)
  - Inpatient Admission Utilization for Individuals with SPMI (MCO-defined)
  - Adherence to Antipsychotic Medications for Individual with Schizophrenia (MCO-defined)
  - Inpatient 30-Day Readmission Rate for Individuals with SPMI (MCO-defined)

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

Conclusions and Comparative Findings

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

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

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

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

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

Preventing Inappropriate Use or Overuse of Opioids

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

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

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

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

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

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

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

In October 2021, GEI submitted an interim report for this project. The MCO updated its topic section to include information specific to its membership population, which further illuminated high-volume and high-risk conditions in the MCO’s specific population. A comparison of baseline MCO rates to national or state benchmarks was not included in the October 2021 interim report. Regarding the alignment of aims, objectives, and interventions for this project, it was reiterated that each performance indicator should be addressed by stating the amount of improvement sought, and the interventions that will be used to achieve this improvement. Performance improvement could not be evaluated.

GEI was encouraged to further develop barriers and methods of barrier analysis. Barriers 1 (Provider Education) and 2 (ED Utilization for Opioid Use) are outcomes, not barriers. Interventions and their corresponding ITMs required additional information, including descriptions for all numerators and denominators for tracking measures, and consistent numbering throughout to allow for logical flow when reading the MCO’s report. Many ITMs were found to be underdeveloped or missing key information. GEI provided data from the annual performance indicators, as well as target rates for each indicator to track progress. No Discussion section was included in GEI’s interim report.

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

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

In October 2023, the evaluation of the MCO's final report revealed several areas that require attention and improvement. Although the plan successfully described how the PIP topic addressed member needs and its importance, there were shortcomings in addressing opportunities for improvement and examining race/ethnicity barriers in the last section. The feedback received through claims review for identified barriers lacked depth, and it was recommended to conduct a more robust barrier analysis using direct member/provider feedback or other QI processes.

Moreover, the interventions and ITMs lacked clarity, focus, and detail. The plan used random sampling of medical record data and core claims data, which should have been discussed in the Sampling section. Throughout the PIP, there were only five ITMs, and interventions targeting susceptible subpopulations were not included. An opportunity existed to develop more robust interventions and ITMs, as demonstrated by the lack of clarity in defining roles, criteria, and distribution details in several instances.

The plan also failed to enhance interventions throughout the course of the PIP. The interpretation of results based on ITM data were missing, and the factors associated with success or failure did not adequately address ITM rates, documented findings from barrier analysis, or modifications to interventions. The Discussion section lacked specific details on ITMs or barrier analysis, and IPRO strongly recommended a thorough examination of threats to internal and external validity.

While the plan mentioned sustained improvement in most indicators from baseline to final measurement, the lack of clarity, focus, and detail in interventions and ITMs, coupled with the absence of a comprehensive discussion on how interventions contributed to the success of performance indicators, made it challenging to determine the specific impact of interventions. Recommendations included recurrent, detailed barrier analysis and modification of low-performing interventions in future PIP submissions. Finally, acknowledging lessons learned and incorporating follow-up activities was commendable, but a more comprehensive approach to addressing identified issues was noted as crucial for future success.

Recommendations were provided to the plan in light of these findings, as noted below. As these recommendations come at the end of this PIP cycle, the MCO is encouraged to consider and implement these recommendations in future PIPs going into MY 2023. **Table A1** of the MCO's interventions for the project can be found in **Appendix A**.

The following recommendations were identified during the second interim report review process:

- It was recommended to update dates of signatures on attestation and accurately input project phase and submission dates. Additionally, the plan should complete the abstract.
- It was recommended to address opportunities for improvement and examine race/ethnicity barriers in the section explaining the opportunity for improvement.
- It was recommended to list interventions implemented and the amount of improvement sought, ensuring each intervention is tied to a performance indicator.
- It was recommended to use the PIP template as a direct guide for the plan.
- It was recommended to discuss random sampling of medical record and core claims data in the Sampling section.
- It was recommended to develop more robust interventions and ITMs by enhancing clarity, focus, and detail, and by specifying roles, criteria, and distribution details for effective impact on the member population, particularly targeting susceptible subpopulations, throughout the course of the PIP.
- It was recommended to develop more effective and efficient ITMs to support interventions impacting the member population.
- It was recommended to interpret results based on ITM implementation and discuss performance indicator improvement.
- It was recommended to consider internal and external threats to validity as influencing factors outside the scope of the PIP.
- It was recommended to examine threats to internal/external validity in the discussion section and discuss specific ITMs or barrier analysis throughout the PIP.
- It was recommended to document lessons learned and follow-up activities.
- It was recommended to conduct a recurrent, detailed barrier analysis and modify low-performing interventions in future PIP submissions.

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

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

Similar to the "Preventing Inappropriate Use or Overuse of Opioids" PIP, for the "Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits" PIP, DHS selected eight performance measures to be included in the PIPs across all MCOs. Three measures are to be collected via HEDIS. The remaining five, all ICP measures, are to be defined by the MCO with certain predetermined parameters. Most of the proposal review recommendations provided to GEI were not addressed. As noted in the PIP review, Performance

Indicator 4, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, was missing the baseline rate. Likewise, Performance Indicator 8, Inpatient 30-Day Readmission Rate for Individuals with SPMI, was missing the baseline and target rates. It should be noted that, as indicated in the proposal documents to the MCOs and training, both Indicators 4 and 8 are required for the PIP and are required to be defined and collected by the MCO, using data from their own systems. Additionally, Performance Indicator 1, Ambulatory Care: ED Visits, Indicator 2, Inpatient Utilization: Total Discharges, Indicator 4, and Indicator 7, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, had rationales for their target rates that referenced the Quality Compass. It was recommended that the MCO clarify if the target rates are referencing the HEDIS 2020 (MY 2019) Quality Compass year. In addition, the MCO was advised that percentiles should be specified in the target rate rationales for Performance Indicators 1 and 4.

In the PIP, the MCO was advised that they should provide performance indicators that are clearly defined and measurable; additionally, they should measure changes in health status, functional status, and satisfaction or processes of care with strong associations with improved outcomes. It was recommended that GEI update Performance Indicator 1 such that the denominator reflects the total member months, as opposed to the total ED visits per 1,000 member months, which is the description of the measure, not the denominator. Further, it was recommended that Performance Indicator 2 should be revised to reflect total member months, as well. The MCO was advised to also define the SPMI criteria for the applicable measures, as referenced in the PIP baseline review. For Indicator 4, the plan was advised that for both Initiation and Engagement, the numerator should state the number (not percentage), and it was recommended that the denominator be comprised of members with a new diagnosis of alcohol and other drug abuse or dependence (rather than all adolescent and adult continuously enrolled members). The MCO was informed that once the MCO incorporates these recommendations, the specifications should allow for indicators to be measured consistently over time, in order to provide a clear trend with potential actionable information. Additionally, the MCO's study design specifies data collection methodologies that are valid and reliable, along with robust data analysis procedures.

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

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

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

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

In October 2022, the MCO submitted a second interim report for this project. Reviewers noted that several previous recommendations were not addressed. Previously, the plan was advised to provide member data for disease prevalence or acute-care utilization, which would include information about racial disparities evident in prevalence or utilization to identify populations at risk and target interventions. No additional information was provided by the plan. The plan was also previously advised to ensure that each performance indicator is addressed by a statement of aims and objectives and that all indicators, including those referencing members with SPMI, be addressed. The plan added aims and objective statements but again did not frame them with descriptions of how the interventions will improve rates for the performance indicators.

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

Regarding results, interim results were provided in the Results table for only four of the eight measures. Additionally, the data provided in the "Indicators and Corresponding Goals" and "Results" table in the MCO's final report did not match, and some previous items were not addressed. Due to this discrepancy, it was not possible to determine if improvements were achieved. As with the previous interim submission and resubmissions and although required in the template, no Discussion section was included in GEI's final report. Recommendations were provided to the plan in light of these findings, as noted below.

In October 2023, the evaluation of the MCO's final report indicated several areas that required attention and improvement. Notably, there were inconsistencies in the documentation, including the absence of dates for project phase and submission on page 2 and a lack of updated dates on signatures. The plan failed to complete the abstract and lacked a comprehensive discussion of quantified high-volume and high-risk aspects within the member groups. Furthermore, disease prevalence, baseline, and benchmarks were not adequately addressed.

A discrepancy was noted regarding the listed aim and objective related to pharmacy outreach, where no intervention or ITM was developed. The plan was strongly encouraged to carefully review the given recommendations and use the PIP template as a direct guide. While the plan stated the intention to validate certain indicators using random sampling of medical record data and core claims data, this process needed to be discussed in the sampling procedures section.

Interventions and ITMs were highlighted as lacking clarity, focus, and detail. Specific instances, such as Intervention 1a and ITM 1a, lacked clarity regarding the connection to and definition of "SAM." Additionally, Intervention 1b and ITM 1b required a more specific denominator definition. There was also a lack of clarity on how certain interventions and ITMs addressed the barrier of "lack of connection to primary care."

While actual start dates were provided, and some interventions were enhanced, alignment issues between interventions and corresponding ITMs were noted, particularly in the case of Intervention 3b and ITM 3b. Modifications to interventions were made based on ITM interpretation, as seen in Intervention 4a. Some indicators demonstrated improvement, while others showed a decline, and a few were unable to be analyzed due to data unavailability. ITMs showed variable improvement.

Factors associated with success or failure mentioned some interventions but failed to address ITM rates, documented findings from barrier analysis, or modifications to interventions. Internal and external threats to validity were recommended to be considered due to influencing factors outside the PIP's scope. Review noted that there appeared to be confusion in differentiating between performance indicators, interventions, barrier analysis, and ITMs, prompting a strong recommendation for an examination of threats to internal/external validity.

Despite sustained improvement in some indicators, the absence of final rate measurements for three out of eight indicators made it challenging to assess the overall results of the PIP. A recurrent, detailed barrier analysis and modification of low-performing interventions were recommended for future submissions. The lack of clarity, focus, and detail in interventions and ITMs, coupled with a deficiency in discussing how interventions contributed to the success of performance indicators, made it difficult to determine the success of interventions in improving overall performance.

Recommendations were provided to the plan in light of these findings, as noted below. As these recommendations come at the end of this PIP cycle, the MCO is encouraged to consider and implement these recommendations in future PIPs going into MY 2023. **Table A1** of the MCO's interventions for the project can be found in **Appendix A**.

The following recommendations were identified during the interim report review process:
- It was recommended to include project phase and submission dates and update dates on signatures to ensure accurate documentation.
- It was recommended to complete the abstract in the PIP.
- It was recommended to discuss quantified high-volume and high-risk aspects within member groups in the narrative.
- It was recommended to address disease prevalence, baseline, and benchmarks in the plan for a more thorough analysis.
- It was recommended to develop interventions and ITMs for aims and objectives listed, ensuring clarity and alignment.
- It was recommended to carefully review recommendations and use the PIP template as a guide for appropriate development.
- It was recommended to discuss the validation process for Indicators 4, 5, 6, and 8 using random sampling of medical record data and core claims data in the sampling procedures.
- It was recommended to clarify the connection between Intervention 1a and ITM 1a, specifying the meaning of "SAM."
- It was recommended to specify the denominator for Intervention 1b and ITM 1b related to BH care management.
- It was recommended to address how Interventions 1a and 1b, under the barrier of "lack of connection to primary care," effectively tackle this barrier.
- It was recommended to define the intervention and specify the meaning of "resolution of concerns" in Intervention 2a related to transportation concerns.

- It was recommended to align Intervention 3b and ITM 3b for consistency in measuring referrals for psychiatric admission.
- It was recommended to ensure clear alignment between interventions and corresponding ITMs throughout the plan and modify interventions as needed based on the interpretation of ITMs, ensuring a cohesive approach.
- It was recommended to demonstrate improvement in Indicators 1, 2, and 3 from baseline to final measurement and address declines in Indicators 4 and 7.
- It was recommended to acknowledge unavailable data for the analysis of improvement in Indicators 5, 6, and 8 from baseline to final measurement.
- It was recommended to interpret performance indicator improvement using ITM data, providing insights into the degree of goal achievement and address factors associated with success or failure, including ITM rates, documented findings from barrier analysis, and modifications to interventions.
- It was recommended to consider internal and external threats to validity due to external influencing factors.
- It was recommended to clarify distinctions between performance indicators, interventions, barrier analysis, and ITMs to avoid confusion.

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

Table 3: GEI PIP Compliance Assessments

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

PIP: performance improvement project; ED: emergency department.

III. Validation of Performance Measures

Objectives

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

Technical Methods of Data Collection and Analysis

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

HEDIS MY 2022 Health Plan measures were validated through a standard HEDIS compliance audit of each PH-MCO. The audit protocol includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of the Interactive Data Submission System (IDSS). For HEDIS MY 2022, audit activities continued to be performed virtually due to the 2019 novel coronavirus (COVID-19) public health emergency. A FAR was submitted to NCQA for each MCO.

Description of Data Obtained

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

Pennsylvania Performance Measures

MCOs collect PAPMs, "which are a set of state quality measures that were developed focusing on specific areas of importance to the commonwealth that are not captured through other available data sets. PAPMs use statistically valid methodologies and allow program offices to track program performance over time. MCOs are required to report specific data for measures according to the requirements of the managed care program(s) in which they participate, and the most current year's measures selected. Data sources include, but are not limited to, encounter data, participant interviews, patient experience surveys, on-site documents, electronic file reviews, quarterly, and annual reports."[16]

CMS Core Set Measures

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

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

HEDIS Health Plan Measures

Each MCO underwent a full HEDIS compliance audit in 2023. Development of HEDIS Health Plan measures and the clinical rationale for their inclusion in the HEDIS Health Plan measurement set can be found in the HEDIS MY 2022, Volume 2 narrative. Each year, DHS updates its requirements for the MCOs to be consistent with NCQA's requirement for the reporting year. MCOs are required to report the complete set of Medicaid measures, excluding measures requiring a BH benefit (BH being carved out in PA), the long-term care and survey measures, as specified in the HEDIS Technical Specifications, Volume 2. In addition, DHS does not require the MCOs to produce the Chronic Conditions component of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Child Survey.

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

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

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

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

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

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

Conclusions and Comparative Findings

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

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

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

In addition to each individual MCO's rate, the Medicaid managed care (MMC) average for MY 2022 is presented. The MMC average is a weighted average, which is an average that takes into account the proportional relevance of each MCO. Each table also presents the significance of the difference between the plan's MY rate and the MMC average for the same year. For comparison of MY 2022 rates to MMC rates, "+" denotes that the plan rate exceeds the MMC rate, "–" denotes that the plan rate is less than the MMC average, and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS Health Plan measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS Health Plan measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage-point difference between two rates was statistically significant in many cases, although not meaningful. Hence, strengths and opportunities corresponding to each table highlight only differences that are both statistically significant and display at least a 3-percentage-point difference in observed rates.[17] It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates might not yield statistical significance due to reduced power; if statistical significance is not achieved, results are not highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, "N/A" (not applicable) appears in the corresponding cells. However, "NA" (not available) also appears in the cells under the HEDIS MY 2022 percentile column for measures that do not have HEDIS percentiles to compare.

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

The measure data tables show rates up to one decimal place. Calculations to determine differences between rates are based upon unrounded rates. Due to rounding, differences in rates that are reported in the narrative may differ slightly from the difference between rates presented in the table.

Access to/Availability of Care

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

Table 4: Access to/Availability of Care Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
PA DHS	Adult Annual Dental Visit	-	Measure is calculated by IPRO	This measure assesses the percentage of adults 21 years of age and older who were continuously enrolled in the MCO for the MY and who had at least one dental visit during the MY.	Rate 1: Members ages 21 years and older. Rate 2: Women ages 21 years and older with a live birth.	Rate 1: Ages 21–35 years, ages 35–59 years, ages 60–64 years, 65 years of age and older, and total ages Rate 2: Ages 21–35 years, ages 36–59 years, and ages 21–59 years
NCQA	Adults' Access to Preventive/Ambulatory Health Services	-	Reported as a HEDIS audited measure	This measure assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during MY 2022.	N/A	Ages 20–44 years, ages 45–64 years, and 65 years of age and older
NCQA	Annual Dental Visit	-	Reported as a HEDIS-audited measure	This measure assesses the percentage of children and adolescents ages 2 to 20 years who were continuously enrolled in the MCO for the MY and who had at least one dental visit during the MY.	N/A	Ages 2–3 years, ages 4–6 years, ages 7–10 years, ages 11–14 years, ages 15–18 years, ages 19–20 years, and total ages
PA DHS	Annual Dental Visits for Members with Developmental Disabilities	-	Measure is calculated by IPRO	This measure assesses the percentage of Members with a developmental disability ages 2 to 20 years who were continuously enrolled and had at least one dental visit during the MY.	N/A	Ages 2–20 years
NCQA	Initiation and Engagement of Substance Use Disorder Treatment	✓	Measure is calculated by IPRO	This measure assesses the percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.	Rate 1: Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. Rate 2: Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. For each rate, the following SUD cohorts are reported: 1) alcohol use disorder; 2) opioid use disorder; 3) other SUD; and 4) the total sum of the SUD diagnosis cohort stratifications.	Ages 13–17 years, 18–64 years, 65 years of age and older, and 13 years of age and older
NCQA	Prenatal and Postpartum Care	✓	Reported as a HEDIS-audited measure	This measure assesses the percentage of deliveries of live births on or between October 8 of the year prior to the MY and October 7 of the MY.	Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	All member ages
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓	Measure is calculated by IPRO	This measure assesses the percentage of children and adolescents ages 1 to 17 years who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	N/A	Ages 1–11 years, ages 12–17 years, and total ages 1–17 years

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

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

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 20 to 44 years) - 5.7 percentage points
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 45 to 64 years) - 3.1 percentage points
  - Adults' Access to Preventive/Ambulatory Health Services (Total) - 4.6 percentage points
  - Annual Dental Visit (Ages 4 to 6 Years) - 4.3 percentage points
  - Annual Dental Visit (Ages 7 to 10 years) - 3.8 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 18 to 64 years) - 3.5 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Total) - 3.3 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 13 to 17 years) – 4.0 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Total) – 4.0 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 18 to 64 years) – 3.8 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Total) – 3.9 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Ages 18 to 64 years) – 3.4 percentage points
  - Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Total) – 3.4 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 65 years and older) - 9.1 percentage points
  - Adults' Access to Preventive/Ambulatory Health Services (Ages 65 years and older) - 7.8 percentage points

Table 5: Access to/Availability of Care Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 21 to 35 years)	50,610	13,718	27.1%	26.7%	27.5%	27.4%	n.s.	28.8%	–	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 36 to 59 years)	53,209	13,497	25.4%	25.0%	25.7%	25.8%	n.s.	27.0%	–	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 60 to 64 years)	7,654	1,705	22.3%	21.3%	23.2%	22.6%	n.s.	24.4%	–	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 65 years and older)	665	92	13.8%	11.1%	16.5%	14.8%	n.s.	22.9%	–	NA
Adult Annual Dental Visit for Members Age 21 Years and Older (Ages 21 years and older)	112,138	29,012	25.9%	25.6%	26.1%	26.2%	n.s.	27.5%	–	NA
Adult Annual Dental Visit: Women with a Live Birth (Ages 21 to 35 years)	2,961	1,010	34.1%	32.4%	35.8%	30.8%	+	32.4%	n.s.	NA
Adult Annual Dental Visit: Women with a Live Birth (Ages 36 to 59 years)	385	111	28.8%	24.2%	33.5%	29.6%	n.s.	31.6%	n.s.	NA
Adult Annual Dental Visit: Women with a Live Birth (Ages 21 to 59 years)	3,346	1,121	33.5%	31.9%	35.1%	30.7%	+	32.3%	n.s.	NA
Adults' Access to Preventive/Ambulatory Health Services (Ages 20 to 44 years)	80,269	64,240	80.0%	79.8%	80.3%	81.6%	–	74.3%	+	≥ 90th percentile
Adults' Access to Preventive/Ambulatory Health Services (Ages 45 to 64 years)	35,957	31,031	86.3%	85.9%	86.7%	86.6%	n.s.	83.2%	+	≥ 75th and < 90th percentile
Adults' Access to Preventive/Ambulatory Health Services (Ages 65 years and older)	666	529	79.4%	76.3%	82.6%	81.9%	n.s.	87.2%	–	≥ 25th and < 50th percentile
Adults' Access to Preventive/Ambulatory Health Services (Total)	116,892	95,800	82.0%	81.7%	82.2%	83.1%	–	77.4%	+	≥ 75th and < 90th percentile
Annual Dental Visit (Ages 2 to 3 years)	10,417	5,801	55.7%	54.7%	56.6%	41.5%	+	53.1%	+	≥ 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Annual Dental Visit (Ages 4 to 6 years)	16,006	11,943	74.6%	73.9%	75.3%	63.0%	+	70.3%	+	≥ 90th percentile
Annual Dental Visit (Ages 7 to 10 years)	21,175	16,160	76.3%	75.7%	76.9%	68.2%	+	72.5%	+	≥ 90th percentile
Annual Dental Visit (Ages 11 to 14 years)	20,639	14,402	69.8%	69.2%	70.4%	59.2%	+	68.0%	+	≥ 90th percentile
Annual Dental Visit (Ages 15 to 18 years)	20,009	12,007	60.0%	59.3%	60.7%	48.7%	+	58.6%	+	≥ 90th percentile
Annual Dental Visit (Ages 19 to 20 years)	9,258	3,469	37.5%	36.5%	38.5%	31.8%	+	38.8%	–	≥ 75th and < 90th percentile
Annual Dental Visit (Total)	97,504	63,782	65.4%	65.1%	65.7%	55.2%	+	63.2%	+	≥ 90th percentile
Annual Dental Visits for Members with Developmental Disabilities	7,737	5,168	66.8%	65.7%	67.9%	54.8%	+	64.7%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 13 to 17 years)[3]	58	23	39.7%	26.2%	53.1%	N/A	N/A	36.1%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 18 to 64 years)[3]	2,199	948	43.1%	41.0%	45.2%	N/A	N/A	41.3%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 65 years and older)[3]	21	12	N/A	N/A	N/A	N/A	N/A	45.2%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Total)[3]	2,278	983	43.2%	41.1%	45.2%	N/A	N/A	41.3%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 13 to 17 years)[3]	14	9	N/A	N/A	N/A	N/A	N/A	56.9%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 18 to 64 years)[3]	1,924	907	47.1%	44.9%	49.4%	N/A	N/A	45.8%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 65 years and older)[3]	4	2	N/A	N/A	N/A	N/A	N/A	42.5%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Total)[3]	1,942	918	47.3%	45.0%	49.5%	N/A	N/A	45.9%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 13 to 17 years)[3]	284	127	44.7%	38.8%	50.7%	N/A	N/A	42.3%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 18 to 64 years)[3]	2,531	1,200	47.4%	45.4%	49.4%	N/A	N/A	44.5%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 65 years and older)[3]	5	2	N/A	N/A	N/A	N/A	N/A	41.1%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Total)[3]	2,820	1,329	47.1%	45.3%	49.0%	N/A	N/A	44.3%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Ages 13 to 17 years)[3]	327	144	44.0%	38.5%	49.6%	N/A	N/A	41.2%	n.s.	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Ages 18 to 64 years) [3]	5,942	2,639	44.4%	43.1%	45.7%	N/A	N/A	42.2%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Ages 65 years and older) [3]	27	14	N/A	N/A	N/A	N/A	N/A	42.3%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of Substance Use Disorder (SUD) Treatment - Total (Total) [3]	6,296	2,797	44.4%	43.2%	45.7%	N/A	N/A	42.2%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 13 to 17 years) [3]	58	10	17.2%	6.7%	27.8%	N/A	N/A	21.8%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 18 to 64 years) [3]	2,199	506	23.0%	21.2%	24.8%	N/A	N/A	19.5%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Ages 65 years and older) [3]	21	3	N/A	N/A	N/A	N/A	N/A	12.9%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Alcohol Use Disorder (Total) [3]	2,278	519	22.8%	21.0%	24.5%	N/A	N/A	19.5%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 13 to 17 years) [3]	14	5	N/A	N/A	N/A	N/A	N/A	39.2%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 18 to 64 years) [3]	1,924	670	34.8%	32.7%	37.0%	N/A	N/A	30.8%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Ages 65 years and older) [3]	4	1	N/A	N/A	N/A	N/A	N/A	23.8%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Opioid Use Disorder (Total) [3]	1,942	676	34.8%	32.7%	37.0%	N/A	N/A	30.8%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 13 to 17 years) [3]	284	76	26.8%	21.4%	32.1%	N/A	N/A	22.7%	n.s.	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 18 to 64 years) [3]	2,531	650	25.7%	24.0%	27.4%	N/A	N/A	21.9%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Ages 65 years and older) [3]	5	1	N/A	N/A	N/A	N/A	N/A	10.7%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Other Drug Use Disorder (Total) [3]	2,820	727	25.8%	24.1%	27.4%	N/A	N/A	21.9%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Ages 13 to 17 years) [3]	327	84	25.7%	20.8%	30.6%	N/A	N/A	22.1%	n.s.	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Ages 18 to 64 years)[3]	5,942	1,544	26.0%	24.9%	27.1%	N/A	N/A	22.6%	+	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Ages 65 years and older)[3]	27	4	N/A	N/A	N/A	N/A	N/A	14.4%	N/A	NA
Initiation and Engagement of Substance Use Disorder Treatment -Engagement of Substance Use Disorder (SUD) Treatment - Total (Total)[3]	6,296	1,632	25.9%	24.8%	27.0%	N/A	N/A	22.5%	+	NA
Prenatal and Postpartum Care - Timeliness of Prenatal Care	411	365	88.8%	85.6%	92.0%	86.4%	n.s.	88.7%	n.s.	≥ 75th and < 90th percentile
Prenatal and Postpartum Care - Postpartum Care	411	327	79.6%	75.5%	83.6%	80.1%	n.s.	81.6%	n.s.	≥ 50th and < 75th percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 11 years)	186	112	60.2%	52.9%	67.5%	73.9%	–	61.9%	n.s.	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17 years)	314	199	63.4%	57.9%	68.9%	67.5%	n.s.	62.5%	n.s.	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	500	311	62.2%	57.8%	66.6%	69.7%	–	62.3%	n.s.	NA

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

Behavioral Health

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

Table 6: Behavioral Health Measure Descriptions

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

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1C) Poor Control (> 9.0%)	✓	Measure is calculated by IPRO	This measure assesses the percentage of beneficiaries ages 18–75 years with a serious mental illness (SMI) and diabetes (type 1 and type 2) whose most recent HbA1c level during the MY was > 9.0%. A lower rate indicates better performance for this measure. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.	N/A	Ages 18–64 years and ages 65–75 years
NCQA	Diabetes Monitoring for People With Diabetes and Schizophrenia	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–64 years with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the MY. MY 2022 is the first report for this measure.	N/A	Ages 18–64 years
NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 18–64 years with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the MY. MY 2022 is the first report for this measure.	N/A	Ages 18–64 years
NCQA	Diagnosed Mental Health Disorders	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year. The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.	N/A	Ages 1–17 years, ages 18–64 years, 65 years of age and older, and total ages
NCQA	Diagnosed Substance Use Disorders	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members 13 years of age and older diagnosed with a substance use disorder (SUD) during the MY. The measure provides information on the diagnosed prevalence of SUDs. Neither a higher nor lower rate indicates better performance.	Rate 1: The percentage of members diagnosed with an alcohol disorder. Rate 2: The percentage of members diagnosed with an opioid disorder. Rate 3: The percentage of members diagnosed with a disorder for other or unspecified drugs. Rate 4: The percentage of members diagnosed with any SUD.	Ages 13–17 years, ages 18–64 years, 65 years of age and older, and total ages
NCQA	Follow-Up After Emergency Department Visit for Mental Illness	✓	Measure is calculated by IPRO	This measure assesses the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit with a corresponding principal diagnosis for mental illness. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.	Rate 1: The percentage of ED visits for mental illness for which the member received follow-up within 7 days of the ED visit (8 total days). Rate 2: The percentage of ED visits for mental illness for which the member received follow-up within 30 days of the ED visit (31 total days).	Ages 6–17 years, 18–64 years, and 65 years of age and older
NCQA	Follow-Up After Emergency Department Visit for Substance Use	✓	Measure is calculated by IPRO	This measure assesses the percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and who had a follow-up visit with a corresponding principal diagnosis for AOD abuse or dependence. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.	Rate 1: The percentage of ED visits for mental illness for which the member received follow-up within 7 days of the ED visit (8 total days). Rate 2: The percentage of ED visits for mental illness for which the member received follow-up within 30 days of the ED visit (31 total days).	Ages 13–17 years, 18–64 years, and 65 years of age and older
NCQA	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	✓	Reported as a HEDIS-audited measure and BH-enhanced[1]	This measure assesses the percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Rate 1: Initiation Phase. The percentage of members ages 6–12 years as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. Rate 2: Continuation and Maintenance Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	Ages 6–12 years

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of children and adolescents ages 1–17 years who had two or more antipsychotic prescriptions and had metabolic testing.	Rate 1: The percentage of children and adolescents on antipsychotics who received blood glucose testing. Rate 2: The percentage of children and adolescents on antipsychotics who received cholesterol testing. Rate 3: The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	Ages 1–11 years, ages 12–17 years, and total ages
NCQA	Pharmacotherapy for Opioid Use Disorder	-	Reported as HEDIS-audited measure	This measure assesses the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members ages 16 years and older with a diagnosis of OUD.	N/A	Ages 16–64 years, 65 years of age and older, and total ages
CMS	Screening for Depression and Follow-Up Plan	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter. MY 2022 is the first report for this measure	N/A	Ages 18–64 years, 65 years of age and older, and total ages
CMS	Use of Pharmacotherapy for Opioid Use Disorder	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of members with an OUD who filled a prescription for or were administered or dispensed a Food and Drug Administration (FDA)-approved medication for the disorder during the MY.	Five rates are reported: a total rate including any medications used in medication-assisted treatment of opioid dependence and addiction, and four separate rates representing the following FDA-approved drug products: 1) buprenorphine; 2) oral naltrexone; 3) long-acting, injectable naltrexone; and 4) methadone.	Ages 18–64 years, 65 years of age and older, and total ages

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

Strengths are identified for MY 2022 BH performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c) Poor Control (> 9.0%) (Ages 18 to 64 years) - 8.6 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 6 to 17 years) - 9.9 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 18 to 64 years) - 8.5 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 6 to 17 years) - 8.4 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 18 to 64 years) - 9.9 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years) - 6.3 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years) - 5.2 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) - 5.4 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 1 to 11 years) - 6.0 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years) - 5.9 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) - 6.0 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years) - 7.2 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years) - 7.0 percentage points
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) - 7.1 percentage points
  - Pharmacotherapy for Opioid Use Disorder (Ages 16 to 64 years) - 6.7 percentage points
  - Pharmacotherapy for Opioid Use Disorder (Total) - 6.6 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Adherence to Antipsychotic Medications for Individuals With Schizophrenia - 6.0 percentage points
  - Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - 5.2 percentage points

- Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - BH Enhanced – 4.8 percentage points
- Screening for Depression and Follow-Up Plan (Ages 65 years and older) - 4.5 percentage points

Table 7: Behavioral Health Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	484	298	61.6%	57.1%	66.0%	64.2%	n.s.	67.5%	–	≥ 50th and < 75th percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia - BH Enhanced	987	683	69.2%	66.3%	72.1%	65.1%	n.s.	71.8%	n.s.	NA
Antidepressant Medication Management - Effective Acute Phase Treatment	5,381	3,478	64.6%	63.3%	65.9%	64.2%	n.s.	62.2%	+	≥ 50th and < 75th percentile
Antidepressant Medication Management - Effective Continuation Phase Treatment	5,381	2,438	45.3%	44.0%	46.6%	44.9%	n.s.	44.5%	n.s.	≥ 50th and < 75th percentile
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	12	12	N/A	N/A	N/A	N/A	N/A	81.6%	N/A	NA
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c) Poor Control (> 9.0%) (Ages 18 to 64 years)	796	717	90.1%	87.9%	92.2%	87.1%	n.s.	81.5%	+	NA
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c) Poor Control (> 9.0%) (Ages 65 to 75 years)	3	3	N/A	N/A	N/A	N/A	N/A	86.0%	N/A	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia	116	91	78.5%	70.5%	86.4%	82.8%	n.s.	76.0%	n.s.	≥ 90th percentile
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1,596	1,417	88.8%	87.2%	90.4%	88.9%	n.s.	86.0%	+	≥ 90th percentile
Diagnosed Mental Health Disorders (Ages 1 to 17 years)	88,914	25,318	28.5%	28.2%	28.8%	N/A	N/A	26.1%	N/A	>= 75th and < 90th percentile
Diagnosed Mental Health Disorders (Ages 18 to 64 years)	126,879	48,606	38.3%	38.0%	38.6%	N/A	N/A	34.9%	N/A	>= 75th and < 90th percentile
Diagnosed Mental Health Disorders (Ages 65 years and older)	752	146	19.4%	16.5%	22.3%	N/A	N/A	39.2%	N/A	>= 10th and < 25th percentile
Diagnosed Mental Health Disorders (Total)	216,545	74,070	34.2%	34.0%	34.4%	N/A	N/A	31.4%	N/A	>= 75th and < 90th percentile
Diagnosed Substance Use Disorders - Alcohol (Ages 13 to 17 years)	25,913	46	0.2%	0.1%	0.2%	N/A	N/A	0.1%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Alcohol (Ages 18 to 64 years)	126,879	2,802	2.2%	2.1%	2.3%	N/A	N/A	2.5%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Alcohol (Ages 65 years and older)	752	6	0.8%	0.1%	1.5%	N/A	N/A	2.1%	N/A	< 10th percentile
Diagnosed Substance Use Disorders - Alcohol (Total)	153,544	2,854	1.9%	1.8%	1.9%	N/A	N/A	2.1%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Any (Ages 13 to 17 years)	25,913	142	0.6%	0.5%	0.6%	N/A	N/A	0.6%	N/A	>= 10th and < 25th percentile
Diagnosed Substance Use Disorders - Any (Ages 18 to 64 years)	126,879	9,712	7.7%	7.5%	7.8%	N/A	N/A	7.8%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Any (Ages 65 years and older)	752	10	1.3%	0.4%	2.2%	N/A	N/A	4.9%	N/A	< 10th percentile
Diagnosed Substance Use Disorders - Any (Total)	153,544	9,864	6.4%	6.3%	6.5%	N/A	N/A	6.5%	N/A	>= 50th and < 75th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Diagnosed Substance Use Disorders - Opioid (Ages 13 to 17 years)	25,913	9	0.0%	0.0%	0.1%	N/A	N/A	0.0%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Opioid (Ages 18 to 64 years)	126,879	6,164	4.9%	4.7%	5.0%	N/A	N/A	4.2%	N/A	>= 75th and < 90th percentile
Diagnosed Substance Use Disorders - Opioid (Ages 65 years and older)	752	4	0.5%	-0.1%	1.1%	N/A	N/A	2.4%	N/A	>= 10th and < 25th percentile
Diagnosed Substance Use Disorders - Opioid (Total)	153,544	6,177	4.0%	3.9%	4.1%	N/A	N/A	3.5%	N/A	>= 75th and < 90th percentile
Diagnosed Substance Use Disorders - Other (Ages 13 to 17 years)	25,913	105	0.4%	0.3%	0.5%	N/A	N/A	0.5%	N/A	>= 10th and < 25th percentile
Diagnosed Substance Use Disorders - Other (Ages 18 to 64 years)	126,879	3,433	2.7%	2.6%	2.8%	N/A	N/A	3.3%	N/A	>= 25th and < 50th percentile
Diagnosed Substance Use Disorders - Other (Ages 65 years and older)	752	0	0.0%	-0.1%	0.1%	N/A	N/A	1.1%	N/A	NA
Diagnosed Substance Use Disorders - Other (Total)	153,544	3,538	2.3%	2.2%	2.4%	N/A	N/A	2.8%	N/A	>= 25th and < 50th percentile
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 6 to 17 years) [3]	785	499	63.6%	60.1%	67.0%	N/A	N/A	53.7%	+	NA
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 18 to 64 years) [3]	1,131	511	45.2%	42.2%	48.1%	52.0%	–	36.7%	+	NA
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Ages 65 years and older) [3]	1	0	N/A	N/A	N/A	N/A	N/A	26.7%	N/A	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 6 to 17 years) [3]	785	624	79.5%	76.6%	82.4%	N/A	N/A	71.1%	+	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 18 to 64 years) [3]	1,131	683	60.4%	57.5%	63.3%	64.8%	–	50.5%	+	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Ages 65 years and older) [3]	1	0	N/A	N/A	N/A	N/A	N/A	46.7%	N/A	NA
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Ages 13 to 17 years) [4]	57	13	22.8%	11.0%	34.6%	N/A	N/A	24.6%	n.s.	NA
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Ages 18 to 64 years) [4]	1,433	508	35.5%	32.9%	38.0%	N/A	N/A	34.4%	n.s.	NA
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Ages 65 years and older) [4]	1	0	N/A	N/A	N/A	N/A	N/A	20.6%	N/A	NA
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Ages 13 to 17 years) [4]	57	19	33.3%	20.2%	46.4%	N/A	N/A	36.4%	n.s.	NA
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Ages 18 to 64 years) [4]	1,433	737	51.4%	48.8%	54.1%	N/A	N/A	49.2%	n.s.	NA
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Ages 65 years and older) [4]	1	0	N/A	N/A	N/A	N/A	N/A	29.4%	N/A	NA
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase	1,277	544	42.6%	39.8%	45.4%	42.4%	n.s.	45.4%	n.s.	≥ 25th and < 50th percentile
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase	502	241	48.0%	43.5%	52.5%	44.3%	n.s.	53.3%	–	≥ 10th and < 25th percentile
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase - BH Enhanced	1,403	596	42.5%	39.9%	45.1%	41.5%	n.s.	44.5%	n.s.	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - BH Enhanced	553	264	47.7%	43.5%	52.0%	45.9%	n.s.	52.5%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years)	463	379	81.9%	78.2%	85.5%	79.4%	n.s.	75.6%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years)	983	827	84.1%	81.8%	86.5%	81.3%	n.s.	78.9%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	1,446	1,206	83.4%	81.4%	85.4%	80.7%	n.s.	78.0%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 1 to 11 years)	463	360	77.8%	73.9%	81.6%	74.2%	n.s.	71.8%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years)	983	728	74.1%	71.3%	76.9%	68.5%	+	68.1%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	1,446	1,088	75.2%	73.0%	77.5%	70.3%	+	69.2%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years)	463	352	76.0%	72.0%	80.0%	71.5%	n.s.	68.8%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years)	983	719	73.1%	70.3%	76.0%	67.2%	+	66.2%	+	≥ 90th percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	1,446	1,071	74.1%	71.8%	76.4%	68.6%	+	66.9%	+	≥ 90th percentile
Pharmacotherapy for Opioid Use Disorder (Ages 16 to 64 years)	2,106	609	28.9%	27.0%	30.9%	28.4%	n.s.	22.2%	+	≥ 50th and < 75th percentile
Pharmacotherapy for Opioid Use Disorder (Ages 65 years and older)	4	1	N/A	N/A	N/A	N/A	N/A	33.8%	N/A	NA
Pharmacotherapy for Opioid Use Disorder (Total)	2,110	610	28.9%	27.0%	30.9%	28.4%	n.s.	22.3%	+	≥ 50th and < 75th percentile
Screening for Depression and Follow-Up Plan (Ages 18 to 64 years)	71,555	2,477	3.5%	3.3%	3.6%	N/A	N/A	4.8%	–	NA
Screening for Depression and Follow-Up Plan (Ages 65 years and older)	762	25	3.3%	2.0%	4.6%	N/A	N/A	7.8%	–	NA
Screening for Depression and Follow-Up Plan (Total)	72,317	2,502	3.5%	3.3%	3.6%	N/A	N/A	4.9%	–	NA
Use of Pharmacotherapy for Opioid Use Disorder: Any Medication	699	524	75.0%	71.7%	78.2%	76.8%	n.s.	76.2%	n.s.	NA
Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine	699	515	73.7%	70.3%	77.0%	73.7%	n.s.	71.3%	n.s.	NA
Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting Injectable Naltrexone	699	10	1.4%	0.5%	2.4%	3.9%	–	3.2%	–	NA
Use of Pharmacotherapy for Opioid Use Disorder: Methadone	699	0	0.0%	-0.1%	0.1%	0.1%	n.s.	3.0%	–	NA
Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone	699	10	1.4%	0.5%	2.4%	2.4%	n.s.	2.5%	n.s.	NA

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

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

Cardiovascular Conditions

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

Table 8: Cardiovascular Conditions Measure Descriptions

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

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

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

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

Table 9: Cardiovascular Conditions Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Ages 18 to 64 years)	343	11	3.2%	1.2%	5.2%	2.5%	n.s.	2.8%	n.s.	≥ 50th and < 75th percentile
Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Ages 65 years and older)	3	0	N/A	N/A	N/A	N/A	N/A	5.7%	N/A	NA
Cardiac Rehabilitation - Initiation - Members Who Attended 2 or More Sessions of Cardiac Rehabilitation Within 30 Days (Total)	346	11	3.2%	1.2%	5.2%	2.5%	n.s.	2.9%	n.s.	≥ 50th and < 75th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Ages 18 to 64 years)	343	18	5.3%	2.7%	7.8%	3.5%	n.s.	3.9%	n.s.	≥ 50th and < 75th percentile
Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Ages 65 years and older)	3	0	N/A	N/A	N/A	N/A	N/A	12.9%	N/A	NA
Cardiac Rehabilitation - Engagement 1 - Members Who Attended 12 or More Sessions of Cardiac Rehabilitation Within 90 Days (Total)	346	18	5.2%	2.7%	7.7%	3.5%	n.s.	4.2%	n.s.	≥ 50th and < 75th percentile
Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 18 to 64 years)	343	18	5.3%	2.7%	7.8%	2.5%	+	3.7%	n.s.	≥ 75th and < 90th percentile
Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 65 years and older)	3	0	N/A	N/A	N/A	N/A	N/A	14.3%	N/A	NA
Cardiac Rehabilitation - Engagement 2 - Members Who Attended 24 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	346	18	5.2%	2.7%	7.7%	2.5%	n.s.	3.9%	n.s.	≥ 50th and < 75th percentile
Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 18 to 64 years)	343	4	1.2%	-0.1%	2.5%	0.7%	n.s.	1.2%	n.s.	≥ 25th and < 50th percentile
Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Ages 65 years and older)	3	0	N/A	N/A	N/A	N/A	N/A	8.6%	N/A	NA
Cardiac Rehabilitation - Achievement - Members Who Attended 36 or More Sessions of Cardiac Rehabilitation Within 180 Days (Total)	346	4	1.2%	-0.1%	2.4%	0.7%	n.s.	1.3%	n.s.	≥ 25th and < 50th percentile
Controlling High Blood Pressure	411	292	71.1%	66.5%	75.6%	67.6%	n.s.	70.3%	n.s.	≥ 75th and < 90th percentile
Persistence of Beta-Blocker Treatment After a Heart Attack	141	118	83.7%	77.2%	90.1%	91.4%	n.s.	85.3%	n.s.	≥ 50th and < 75th percentile
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Males ages 21 to 75 years)	977	855	87.5%	85.4%	89.6%	86.0%	n.s.	85.0%	+	≥ 90th percentile
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Females ages 40 to 75 years)	592	493	83.3%	80.2%	86.4%	86.5%	n.s.	83.1%	n.s.	≥ 75th and < 90th percentile
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	1,569	1,348	85.9%	84.2%	87.7%	86.2%	n.s.	84.2%	n.s.	≥ 90th percentile
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Males ages 21 to 75 years)	855	676	79.1%	76.3%	81.8%	77.4%	n.s.	78.0%	n.s.	≥ 75th and < 90th percentile
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Females ages 40 to 75 years)	493	384	77.9%	74.1%	81.7%	76.0%	n.s.	79.0%	n.s.	≥ 75th and < 90th percentile
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	1,348	1,060	78.6%	76.4%	80.9%	76.8%	n.s.	78.4%	n.s.	≥ 75th and < 90th percentile

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

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

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

Dental and Oral Health Services

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

Table 10: Dental and Oral Health Services Measure Descriptions

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

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

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

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Sealant Receipt on Permanent First Year Molars - At Least One Sealant - 20.2 percentage points
  - Sealant Receipt on Permanent First Year Molars - All Four Molars Sealed - 13.5 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 3 to 5 years) - 3.7 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 6 to 7 years) - 5.8 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 8 to 9 years) - 6.0 percentage points
  - Topical Fluoride for Children - Dental Services (Ages 10 to 11 years) - 5.3 percentage points
  - Topical Fluoride for Children - Dental Services (Age 12 to 14 years) - 3.4 percentage points
  - Topical Fluoride for Children - Dental Services (Total) - 3.0 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Ages 6 to 7 years) - 5.6 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Ages 8 to 9 years) - 5.9 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Ages 10 to 11 years) - 5.3 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Age 12 to 14 years) - 3.4 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Topical Fluoride for Children - Oral Health Services (Ages 1 to 2 years) - 4.8 percentage points
  - Topical Fluoride for Children - Dental or Oral Health Services (Ages 1 to 2 years) - 6.6 percentage points

Table 11: Dental and Oral Health Services Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Oral Evaluation - Dental Services (Ages less than 1 year)	2,218	23	1.0%	0.6%	1.5%	0.9%	n.s.	1.2%	n.s.	NA
Oral Evaluation - Dental Services (Ages 1 to 2 years)	10,399	2,445	23.5%	22.7%	24.3%	16.6%	+	25.5%	–	NA
Oral Evaluation - Dental Services (Ages 3 to 5 years)	17,040	9,018	52.9%	52.2%	53.7%	40.7%	+	52.7%	n.s.	NA
Oral Evaluation - Dental Services (Ages 6 to 7 years)	11,357	7,050	62.1%	61.2%	63.0%	50.4%	+	60.7%	+	NA
Oral Evaluation - Dental Services (Ages 8 to 9 years)	11,154	7,091	63.6%	62.7%	64.5%	49.0%	+	60.8%	+	NA
Oral Evaluation - Dental Services (Ages 10 to 11 years)	10,964	6,455	58.9%	57.9%	59.8%	46.5%	+	57.5%	+	NA
Oral Evaluation - Dental Services (Age 12 to 14 years)	16,265	8,634	53.1%	52.3%	53.9%	42.5%	+	53.0%	n.s.	NA
Oral Evaluation - Dental Services (Ages 15 to 18 years)	21,085	8,696	41.2%	40.6%	41.9%	33.7%	+	42.1%	–	NA
Oral Evaluation - Dental Services (Ages 19 to 20 years)	10,006	2,394	23.9%	23.1%	24.8%	21.1%	+	25.0%	–	NA
Oral Evaluation - Dental Services (Total)	110,488	51,806	46.9%	46.6%	47.2%	37.0%	+	47.1%	n.s.	NA
Sealant Receipt on Permanent First Year Molars - At Least One Sealant	5,091	2,559	50.3%	48.9%	51.6%	48.4%	n.s.	30.1%	+	NA
Sealant Receipt on Permanent First Year Molars - All Four Molars Sealed	5,091	1,702	33.4%	32.1%	34.7%	30.8%	+	19.9%	+	NA
Topical Fluoride for Children - Dental Services (Ages 1 to 2 years)	9,688	813	8.4%	7.8%	8.9%	4.3%	+	7.1%	+	NA
Topical Fluoride for Children - Dental Services (Ages 3 to 5 years)	16,070	4,194	26.1%	25.4%	26.8%	15.8%	+	22.4%	+	NA
Topical Fluoride for Children - Dental Services (Ages 6 to 7 years)	10,779	3,563	33.1%	32.2%	33.9%	21.8%	+	27.3%	+	NA
Topical Fluoride for Children - Dental Services (Ages 8 to 9 years)	10,567	3,432	32.5%	31.6%	33.4%	20.0%	+	26.5%	+	NA
Topical Fluoride for Children - Dental Services (Ages 10 to 11 years)	10,433	3,058	29.3%	28.4%	30.2%	18.8%	+	24.0%	+	NA
Topical Fluoride for Children - Dental Services (Age 12 to 14 years)	15,449	3,632	23.5%	22.8%	24.2%	16.4%	+	20.1%	+	NA
Topical Fluoride for Children - Dental Services (Ages 15 to 18 years)	20,029	2,014	10.1%	9.6%	10.5%	6.8%	+	9.1%	+	NA
Topical Fluoride for Children - Dental Services (Ages 19 to 20 years)	9,257	14	0.2%	0.1%	0.2%	0.1%	n.s.	0.4%	–	NA
Topical Fluoride for Children - Dental Services (Total)	102,272	20,720	20.3%	20.0%	20.5%	13.0%	+	17.3%	+	NA
Topical Fluoride for Children - Oral Health Services (Ages 1 to 2 years)	9,688	178	1.8%	1.6%	2.1%	0.0%	n.s.	6.7%	–	NA
Topical Fluoride for Children - Oral Health Services (Ages 3 to 5 years)	16,070	42	0.3%	0.2%	0.3%	0.0%	n.s.	0.6%	–	NA
Topical Fluoride for Children - Oral Health Services (Ages 6 to 7 years)	10,779	1	0.0%	0.0%	0.0%	0.0%	n.s.	0.0%	n.s.	NA
Topical Fluoride for Children - Oral Health Services (Ages 8 to 9 years)	10,567	0	0.0%	N/A	N/A	0.0%	n.s.	0.0%	N/A	NA
Topical Fluoride for Children - Oral Health Services (Ages 10 to 11 years)	10,433	0	0.0%	N/A	N/A	0.0%	n.s.	0.0%	N/A	NA
Topical Fluoride for Children - Oral Health Services (Age 12 to 14 years)	15,449	0	0.0%	N/A	N/A	0.0%	n.s.	0.0%	N/A	NA
Topical Fluoride for Children - Oral Health Services (Ages 15 to 18 years)	20,029	0	0.0%	N/A	N/A	0.0%	n.s.	0.0%	N/A	NA
Topical Fluoride for Children - Oral Health Services (Ages 19 to 20 years)	9,257	0	0.0%	N/A	N/A	0.0%	n.s.	N/A	N/A	NA
Topical Fluoride for Children - Oral Health Services (Total)	102,272	221	0.2%	0.2%	0.2%	0.0%	n.s.	0.8%	–	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Topical Fluoride for Children - Dental or Oral Health Services (Ages 1 to 2 years)	9,688	1,056	10.9%	10.3%	11.5%	8.4%	+	17.5%	–	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 3 to 5 years)	16,070	4,326	26.9%	26.2%	27.6%	21.5%	+	25.7%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 6 to 7 years)	10,779	3,580	33.2%	32.3%	34.1%	28.5%	+	27.6%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 8 to 9 years)	10,567	3,444	32.6%	31.7%	33.5%	26.8%	+	26.7%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 10 to 11 years)	10,433	3,074	29.5%	28.6%	30.3%	25.1%	+	24.2%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Age 12 to 14 years)	15,449	3,657	23.7%	23.0%	24.3%	21.4%	+	20.2%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 15 to 18 years)	20,029	2,033	10.2%	9.7%	10.6%	8.7%	+	9.2%	+	NA
Topical Fluoride for Children - Dental or Oral Health Services (Ages 19 to 20 years)	9,257	15	0.2%	0.1%	0.2%	0.2%	n.s.	0.4%	–	NA
Topical Fluoride for Children - Dental or Oral Health Services (Total)	102,272	21,185	20.7%	20.5%	21.0%	17.5%	+	19.0%	+	NA

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

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

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

Diabetes

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

Table 12: Diabetes Measure Descriptions

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

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

Strengths are identified for MY 2022 Diabetes performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Blood Pressure Control for Patients With Diabetes - 8.6 percentage points
  - Eye Exam for Patients With Diabetes - 9.7 percentage points
  - Kidney Health Evaluation for Patients With Diabetes (Ages 18 to 64 years) - 10.3 percentage points
  - Kidney Health Evaluation for Patients With Diabetes (Ages 65 to 74 years) - 17.0 percentage points
  - Kidney Health Evaluation for Patients With Diabetes (Ages 75 to 85 years) - 26.8 percentage points
  - Kidney Health Evaluation for Patients With Diabetes (Total) - 10.1 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Statin Therapy for Patients With Diabetes - Received Statin Therapy - 4.0 percentage points

Table 13: Diabetes Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Blood Pressure Control for Patients With Diabetes	411	328	79.8%	75.8%	83.8%	78.6%	n.s.	71.2%	+	≥ 90th percentile
Eye Exam for Patients With Diabetes	411	278	67.6%	63.0%	72.3%	64.7%	n.s.	57.9%	+	≥ 90th percentile
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (< 8%)	411	249	60.6%	55.7%	65.4%	55.7%	n.s.	58.1%	n.s.	≥ 90th percentile
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control (> 9.0%)	411	120	29.2%	24.7%	33.7%	29.0%	n.s.	32.3%	n.s.	≥ 90th percentile
Kidney Health Evaluation for Patients With Diabetes (Ages 18 to 64 years)	10,834	6,037	55.7%	54.8%	56.7%	43.2%	+	45.4%	+	≥ 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Kidney Health Evaluation for Patients With Diabetes (Ages 65 to 74 years)	115	81	70.4%	61.7%	79.2%	60.8%	n.s.	53.4%	+	≥ 90th percentile
Kidney Health Evaluation for Patients With Diabetes (Ages 75 to 85 years)	50	39	78.0%	65.5%	90.5%	64.1%	n.s.	51.2%	+	≥ 90th percentile
Kidney Health Evaluation for Patients With Diabetes (Total)	10,999	6,157	56.0%	55.0%	56.9%	43.5%	+	45.9%	+	≥ 90th percentile
Statin Therapy for Patients With Diabetes - Received Statin Therapy	5,786	3,836	66.3%	65.1%	67.5%	68.6%	–	70.3%	–	≥ 50th and < 75th percentile
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	3,836	2,842	74.1%	72.7%	75.5%	74.0%	n.s.	75.0%	n.s.	≥ 75th and < 90th percentile

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

Electronic Clinical Data Systems

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

Table 14: Electronic Clinical Data Systems Measure Descriptions

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

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	-	Reported as HEDIS-audited measure	This measure assesses the percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. This measure is calculated using electronic clinical data.	Rate 1: Initiation Phase. The percentage of members ages 6–12 years as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. Rate 2: Continuation and Maintenance Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	Ages 6–12 years
NCQA	Immunizations for Adolescents	-	Reported as HEDIS-audited measure	This measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (TDaP) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. This measure is calculated using electronic clinical data.	The measure calculates a rate for each vaccine and two combination rates. Combination 1 includes the meningococcal and TDaP vaccine, and Combination 2 includes all three vaccinations.	13 years of age
NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics	-	Reported as HEDIS-audited measure	This measure assesses the percentage of children and adolescents ages 1–17 years who had two or more antipsychotic prescriptions and had metabolic testing. This measure is calculated using electronic clinical data.	Rate 1: The percentage of children and adolescents on antipsychotics who received blood glucose testing. Rate 2: The percentage of children and adolescents on antipsychotics who received cholesterol testing. Rate 3: The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	Ages 1–11 years, ages 12–17 years, and total ages
NCQA	Postpartum Depression Screening and Follow-Up	-	Reported as HEDIS-audited measure	This measure assesses the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care. This measure is calculated using electronic clinical data.	Rate 1: Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. Rate 2: Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	All member ages
NCQA	Prenatal Depression Screening and Follow-Up	-	Reported as HEDIS-audited measure	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. This measure is calculated using electronic clinical data.	Rate 1: Depression Screening. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. Rate 2: Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding	All member ages
NCQA	Prenatal Immunization Status	-	Reported as HEDIS-audited measure	The percentage of deliveries in the measurement period in which women had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (TDaP) vaccinations. This measure is calculated using electronic clinical data.	N/A	All member ages

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

Strengths are identified for MY 2022 ECDS performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Adult Immunization Status - Td/TDaP (Ages 19 to 65 years) - 9.3 percentage points
  - Adult Immunization Status - Zoster (Ages 50 to 65 years) - 4.8 percentage points
  - Childhood Immunization Status - DTaP - 3.8 percentage points
  - Childhood Immunization Status - Hepatitis B - 4.5 percentage points
  - Childhood Immunization Status - IPV - 4.2 percentage points
  - Childhood Immunization Status - Pneumococcal Conjugate - 4.6 percentage points
  - Childhood Immunization Status - Combo 7 - 3.0 percentage points
  - Childhood Immunization Status - Combo 3 - 4.5 percentage points

- Colorectal Cancer Screening (Ages 50 to 75 years) - 4.0 percentage points
- Colorectal Cancer Screening (Total) - 3.1 percentage points
- Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 12 to 17 years) - 11.3 percentage points
- Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 18 to 64 years) - 7.5 percentage points
- Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 65 years and older) - 5.8 percentage points
- Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total) - 8.3 percentage points
- Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 12 to 17 years) - 16.3 percentage points
- Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 18 to 64 years) - 7.3 percentage points
- Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total) - 8.5 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years) - 6.3 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years) - 5.3 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) - 5.5 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 1 to 11 years) - 6.0 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years) - 5.9 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) - 6.0 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years) - 7.2 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years) - 7.0 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) - 7.2 percentage points
- Postpartum Depression Screening and Follow-Up - Depression Screening - 8.9 percentage points
- Prenatal Depression Screening and Follow-Up - Depression Screening - 19.2 percentage points
- Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen - 12.5 percentage points
- Prenatal Immunization Status - TDaP - 3.3 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Childhood Immunization Status - Influenza - 4.9 percentage points
  - Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase - 5.2 percentage points
  - Immunizations for Adolescents - HPV - 5.7 percentage points
  - Immunizations for Adolescents - Combination 2 - 5.6 percentage points

Table 15: Electronic Clinical Data Systems Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Adult Immunization Status - Influenza (Ages 19 to 65 years)	110,328	19,639	17.8%	17.6%	18.0%	19.9%	–	16.8%	+	≥ 75th and < 90th percentile
Adult Immunization Status - Td/TDaP (Ages 19 to 65 years)	110,328	60,880	55.2%	54.9%	55.5%	49.9%	+	45.9%	+	≥ 75th and < 90th percentile
Adult Immunization Status - Zoster (Ages 50 to 65 years)	22,193	3,589	16.2%	15.7%	16.7%	12.2%	+	11.4%	+	≥ 90th percentile
Breast Cancer Screening	10,164	5,820	57.3%	56.3%	58.2%	55.2%	+	55.0%	+	≥ 50th and < 75th percentile
Childhood Immunization Status - DTaP	4,832	3,607	74.7%	73.4%	75.9%	N/A	N/A	70.8%	+	NA
Childhood Immunization Status - Hepatitis A	4,832	3,994	82.7%	81.6%	83.7%	N/A	N/A	83.3%	n.s.	NA
Childhood Immunization Status - Hepatitis B	4,832	4,327	89.6%	88.7%	90.4%	N/A	N/A	85.0%	+	NA
Childhood Immunization Status - HiB	4,832	4,098	84.8%	83.8%	85.8%	N/A	N/A	84.4%	n.s.	NA
Childhood Immunization Status - Influenza	4,832	1,923	39.8%	38.4%	41.2%	N/A	N/A	44.7%	–	NA
Childhood Immunization Status - IPV	4,832	4,335	89.7%	88.8%	90.6%	N/A	N/A	85.5%	+	NA
Childhood Immunization Status - MMR	4,832	4,229	87.5%	86.6%	88.5%	N/A	N/A	86.4%	+	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Childhood Immunization Status - Pneumococcal Conjugate	4,832	3,758	77.8%	76.6%	79.0%	N/A	N/A	73.2%	+	NA
Childhood Immunization Status - Rotavirus	4,832	3,455	71.5%	70.2%	72.8%	N/A	N/A	68.7%	+	NA
Childhood Immunization Status - VZV	4,832	4,192	86.8%	85.8%	87.7%	N/A	N/A	86.1%	n.s.	NA
Childhood Immunization Status - Combo 7	4,832	2,813	58.2%	56.8%	59.6%	N/A	N/A	55.2%	+	NA
Childhood Immunization Status - Combo 3	4,832	3,326	68.8%	67.5%	70.1%	N/A	N/A	64.3%	+	NA
Childhood Immunization Status - Combo 10	4,832	1,473	30.5%	29.2%	31.8%	N/A	N/A	32.5%	–	NA
Colorectal Cancer Screening (Ages 46 to 49 years)	6,809	1,598	23.5%	22.5%	24.5%	N/A	N/A	20.9%	+	NA
Colorectal Cancer Screening (Ages 50 to 75 years)	22,257	10,477	47.1%	46.4%	47.7%	N/A	N/A	43.1%	+	NA
Colorectal Cancer Screening (Total)	29,066	12,075	41.5%	41.0%	42.1%	N/A	N/A	38.4%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 12 to 17 years)	25,842	3,663	14.2%	13.7%	14.6%	10.9%	+	2.8%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 18 to 64 years)	90,971	10,200	11.2%	11.0%	11.4%	9.8%	+	3.7%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Ages 65 years and older)	484	40	8.3%	5.7%	10.8%	4.9%	+	2.5%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)	117,297	13,903	11.9%	11.7%	12.0%	10.0%	+	3.5%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 12 to 17 years)	573	435	75.9%	72.3%	79.5%	77.7%	n.s.	59.6%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 18 to 64 years)	1,355	932	68.8%	66.3%	71.3%	60.9%	+	61.5%	+	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Ages 65 years and older)	1	0	N/A	N/A	N/A	N/A	N/A	40.7%	N/A	NA
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)	1,929	1,367	70.9%	68.8%	72.9%	65.3%	+	62.4%	+	NA
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Initiation Phase	1,277	544	42.6%	39.8%	45.4%	42.3%	n.s.	45.3%	n.s.	NA
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase	502	241	48.0%	43.5%	52.5%	44.4%	n.s.	53.2%	–	NA
Immunizations for Adolescents - HPV	5,069	1,672	33.0%	31.7%	34.3%	N/A	N/A	38.7%	–	NA
Immunizations for Adolescents - Meningococcal	5,069	4,331	85.4%	84.5%	86.4%	N/A	N/A	85.1%	n.s.	NA
Immunizations for Adolescents - TDaP	5,069	4,356	85.9%	85.0%	86.9%	N/A	N/A	85.7%	n.s.	NA
Immunizations for Adolescents - Combination 1	5,069	4,280	84.4%	83.4%	85.4%	N/A	N/A	84.2%	n.s.	NA
Immunizations for Adolescents - Combination 2	5,069	1,642	32.4%	31.1%	33.7%	N/A	N/A	38.0%	–	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 1 to 11 years)	463	379	81.9%	78.2%	85.5%	N/A	N/A	75.6%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Ages 12 to 17 years)	983	827	84.1%	81.8%	86.5%	N/A	N/A	78.8%	+	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	1,446	1,206	83.4%	81.4%	85.4%	N/A	N/A	77.9%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 1 to 11 years)	463	360	77.8%	73.9%	81.6%	N/A	N/A	71.8%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Ages 12 to 17 years)	983	728	74.1%	71.3%	76.9%	N/A	N/A	68.1%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	1,446	1,088	75.2%	73.0%	77.5%	N/A	N/A	69.2%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 1 to 11 years)	463	352	76.0%	72.0%	80.0%	N/A	N/A	68.8%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Ages 12 to 17 years)	983	719	73.1%	70.3%	76.0%	N/A	N/A	66.1%	+	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	1,446	1,071	74.1%	71.8%	76.4%	N/A	N/A	66.9%	+	NA
Postpartum Depression Screening and Follow-Up - Depression Screening	4,214	1,658	39.4%	37.9%	40.8%	32.9%	+	30.5%	+	≥ 90th percentile
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen	337	204	60.5%	55.2%	65.9%	55.1%	n.s.	59.7%	n.s.	≥ 25th and < 50th percentile
Prenatal Depression Screening and Follow-Up - Depression Screening	3,810	1,937	50.8%	49.2%	52.4%	44.6%	+	31.6%	+	≥ 90th percentile
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen	556	352	63.3%	59.2%	67.4%	59.6%	n.s.	50.8%	+	≥ 75th and < 90th percentile
Prenatal Immunization Status - Influenza	3,814	1,124	29.5%	28.0%	30.9%	32.1%	–	30.3%	n.s.	≥ 50th and < 75th percentile
Prenatal Immunization Status - TDaP	3,814	2,732	71.6%	70.2%	73.1%	67.9%	+	68.3%	+	≥ 75th and < 90th percentile
Prenatal Immunization Status - Combination	3,814	1,026	26.9%	25.5%	28.3%	28.2%	n.s.	26.8%	n.s.	≥ 50th and < 75th percentile

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

Maternal and Perinatal Health

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

Table 16: Maternal and Perinatal Health Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
OPA	Contraceptive Care - All Women	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of women ages 15–44 years at risk of unintended pregnancy who were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC).	Rate 1: Provision of most or moderately effective contraception. Rate 2: Provision of LARC.	Ages 15–20 years and ages 21–44 years
OPA	Contraceptive Care - Postpartum Women	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of women ages 15–44 years who had a live birth and were provided a most effective/moderately effective contraception method or a LARC within 3 days and within 60 days of delivery.	Rate 1: Most or moderately effective contraception – 3 days Rate 2: Most or moderately effective contraception – 60 days Rate 3: LARC – 3 days Rate 4: LARC – 60 days.	Ages 15–20 years and ages 21–44 years
PA DHS	Perinatal Depression Screening	-	Measure is calculated by IPRO	This measure assesses the percentage of women screened for depression and provided further treatment during perinatal care. This measure uses components of the HEDIS MY 2022 Prenatal and Postpartum Care Health Plan measure.	Rate 1: Screened for depression during a prenatal care visit. Rate 2: Screened for depression during a prenatal care visit using a validated depression screening tool. Rate 3: Screened for depression during the time frame of the first two prenatal care visits (Children's Health Insurance Program Reauthorization Act [CHIPRA] indicator). Rate 4: Screened positive for depression during a prenatal care visit. Rate 5: Screened positive for depression during a prenatal care visit and had evidence of further evaluation, treatment, or referral for further treatment. Rate 6: Screened for depression during a postpartum care visit. Rate 7: Screened for depression during a postpartum care visit using a validated depression screening tool. Rate 8: Screened positive for depression during a postpartum care visit. Rate 9: Screened positive for depression during a postpartum care visit and had evidence of further evaluation, treatment, or referral for further treatment.	All member ages

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

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

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

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Contraceptive Care - All Women - Most or Moderately Effective Contraception (Ages 15 to 20 years) - 5.3 percentage points
  - Perinatal Depression Screening: Screened positive for depression during a prenatal care visit - 10.1 percentage points
  - Perinatal Depression Screening: Screened positive for depression during a postpartum care visit - 5.9 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking - 8.5 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) - 8.9 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking - 16.7 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke Exposure (ETS) – 18.9 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 90 Days of Delivery (Ages 21 to 44 years) - 3.2 percentage points
  - Perinatal Depression Screening: Screened for depression during a prenatal care visit - 4.1 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS) - 6.1 percentage points
  - Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation - 13.7 percentage points

Table 17: Maternal and Perinatal Health Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Contraceptive Care - All Women - Most or Moderately Effective Contraception (Ages 15 to 20 years)	13,677	4,544	33.2%	32.4%	34.0%	33.5%	n.s.	27.9%	+	NA
Contraceptive Care - All Women - Most or Moderately Effective Contraception (Ages 21 to 44 years)	39,724	10,585	26.6%	26.2%	27.1%	26.6%	n.s.	25.9%	+	NA
Contraceptive Care - All Women - Long-Acting Reversible Method of Contraception (LARC) (Ages 15 to 20 years)	13,677	414	3.0%	2.7%	3.3%	3.1%	n.s.	3.0%	n.s.	NA
Contraceptive Care - All Women - Long-Acting Reversible Method of Contraception (LARC) (Ages 21 to 44 years)	39,724	1,458	3.7%	3.5%	3.9%	3.9%	n.s.	3.8%	n.s.	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 3 Days of Delivery (Ages 15 to 20 years)	289	34	11.8%	7.9%	15.7%	8.6%	n.s.	15.6%	n.s.	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 3 Days of Delivery (Ages 21 to 44 years)	2,862	476	16.6%	15.3%	18.0%	16.3%	n.s.	19.0%	–	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 90 Days of Delivery (Ages 15 to 20 years)	289	157	54.3%	48.4%	60.2%	38.0%	+	53.6%	n.s.	NA
Contraceptive Care - Postpartum Women - Most or Moderately Effective Contraception – Within 90 Days of Delivery (Ages 21 to 44 years)	2,862	1,357	47.4%	45.6%	49.3%	39.1%	+	49.6%	–	NA
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 3 Days of Delivery (Ages 15 to 20 years)	289	19	6.6%	3.5%	9.6%	4.7%	n.s.	8.5%	n.s.	NA
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 3 Days of Delivery (Ages 21 to 44 years)	2,862	102	3.6%	2.9%	4.3%	4.2%	n.s.	5.9%	–	NA
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 90 Days of Delivery (Ages 15 to 20 years)	289	58	20.1%	15.3%	24.9%	11.1%	+	19.2%	n.s.	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Contraceptive Care - Postpartum Women - Long-Acting Reversible Method of Contraception (LARC) – Within 90 Days of Delivery (Ages 21 to 44 years)	2,862	329	11.5%	10.3%	12.7%	9.5%	+	14.7%	–	NA
Perinatal Depression Screening: Screened for depression during a prenatal care visit	406	333	82.0%	78.2%	85.9%	82.5%	n.s.	86.1%	–	NA
Perinatal Depression Screening: Screened for depression during a prenatal care visit using a validated depression screening tool	406	237	58.4%	53.5%	63.3%	54.4%	n.s.	56.5%	n.s.	NA
Perinatal Depression Screening: Screened for depression during the time frame of the first two prenatal care visits (CHIPRA Indicator)	406	328	80.8%	76.8%	84.7%	82.5%	n.s.	77.0%	n.s.	NA
Perinatal Depression Screening: Screened positive for depression during a prenatal care visit	333	106	31.8%	26.7%	37.0%	24.3%	+	21.7%	+	NA
Perinatal Depression Screening: Screened positive for depression during a prenatal care visit and had evidence of further evaluation or treatment or referral for further treatment	106	93	87.7%	81.0%	94.5%	80.0%	n.s.	82.0%	n.s.	NA
Perinatal Depression Screening: Screened for depression during a postpartum care visit	329	295	89.7%	86.2%	93.1%	86.9%	n.s.	86.2%	n.s.	NA
Perinatal Depression Screening: Screened for depression during a postpartum care visit using a validated depression screening tool	329	232	70.5%	65.4%	75.6%	67.0%	n.s.	73.2%	n.s.	NA
Perinatal Depression Screening: Screened positive for depression during a postpartum care visit	295	74	25.1%	20.0%	30.2%	23.2%	n.s.	19.2%	+	NA
Perinatal Depression Screening: Screened positive for depression during a postpartum care visit and had evidence of further evaluation or treatment or referral for further treatment	74	70	94.6%	88.8%	100.4%	87.3%	n.s.	89.8%	n.s.	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking	406	381	93.8%	91.4%	96.3%	92.5%	n.s.	85.4%	+	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	406	381	93.8%	91.4%	96.3%	92.5%	n.s.	84.9%	+	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS)	406	201	49.5%	44.5%	54.5%	51.4%	n.s.	55.6%	–	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Smoking	111	93	83.8%	76.5%	91.1%	79.4%	n.s.	67.1%	+	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Counseling for Environmental Tobacco Smoke Exposure (ETS)	61	58	95.1%	88.8%	101.3%	83.5%	+	76.2%	+	NA
Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit: Prenatal Smoking Cessation	111	12	10.8%	4.6%	17.0%	19.8%	n.s.	24.6%	–	NA

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

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

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

Overuse/Appropriateness

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

Table 18: Overuse/Appropriateness Measure Descriptions

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

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

No strengths are identified for MY 2022 Overuse/Appropriateness performance measures.

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months to 17 years) - 8.3 percentage points
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total) - 4.9 percentage points

Table 19: Overuse/Appropriateness Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Appropriate Treatment for Upper Respiratory Infection (Ages 3 months to 17 years)	29,573	2,310	92.2%	91.9%	92.5%	93.4%	–	95.1%	–	≥ 25th and < 50th percentile
Appropriate Treatment for Upper Respiratory Infection (Ages 18 to 64 years)	10,967	1,777	83.8%	83.1%	84.5%	82.9%	n.s.	84.9%	–	≥ 50th and < 75th percentile
Appropriate Treatment for Upper Respiratory Infection (Ages 65 years and older)	19	3	N/A	N/A	N/A	N/A	N/A	72.3%	N/A	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	40,559	4,090	89.9%	89.6%	90.2%	89.9%	n.s.	92.5%	–	≥ 25th and < 50th percentile
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months to 17 years)	2,131	643	69.8%	67.9%	71.8%	66.2%	n.s.	78.2%	–	≥ 25th and < 50th percentile
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 18 to 64 years)	1,781	850	52.3%	49.9%	54.6%	49.3%	n.s.	50.5%	n.s.	≥ 75th and < 90th percentile
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 65 years and older)	5	4	N/A	N/A	N/A	N/A	N/A	36.3%	N/A	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	3,917	1,497	61.8%	60.2%	63.3%	55.0%	+	66.7%	–	≥ 50th and < 75th percentile
Concurrent Use of Opioids and Benzodiazepines (Ages 18 to 64 years)	1,306	250	19.1%	17.0%	21.3%	19.3%	n.s.	16.4%	+	NA
Concurrent Use of Opioids and Benzodiazepines (Ages 65 years and older)	5	1	N/A	N/A	N/A	N/A	N/A	18.5%	N/A	NA
Concurrent Use of Opioids and Benzodiazepines (Total)	1,311	251	19.1%	17.0%	21.3%	19.4%	n.s.	16.6%	+	NA
Non-Recommended Cervical Cancer Screening in Adolescent Females	11,510	99	0.9%	0.7%	1.0%	0.9%	n.s.	0.2%	+	≥ 10th and < 25th percentile
Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 18 to 64 years)	10,981	263	2.4%	2.1%	2.7%	2.6%	n.s.	3.7%	–	≥ 75th and < 90th percentile
Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Ages 65 years and older)	22	0	N/A	N/A	N/A	N/A	N/A	14.8%	N/A	NA
Risk of Continued Opioid Use - At Least 15 Days of Prescription Opioids in a 30-day Period (Total)	11,003	263	2.4%	2.1%	2.7%	2.6%	n.s.	3.9%	–	≥ 75th and < 90th percentile
Risk of Continued Opioid Use - At Least 31 Days of prescription Opioids in a 62-day Period (Ages 18 to 64 years)	10,981	186	1.7%	1.4%	1.9%	1.5%	n.s.	2.5%	–	≥ 75th and < 90th percentile
Risk of Continued Opioid Use - At Least 31 Days of prescription Opioids in a 62-day Period (Ages 65 years and older)	22	0	N/A	N/A	N/A	N/A	N/A	7.7%	N/A	NA
Risk of Continued Opioid Use - At Least 31 Days of prescription Opioids in a 62-day Period (Total)	11,003	186	1.7%	1.4%	1.9%	1.5%	n.s.	2.6%	–	≥ 75th and < 90th percentile
Use of Imaging Studies for Low Back Pain (Age 18 to 64 years)	4,624	1,223	73.6%	72.3%	74.8%	73.4%	n.s.	75.7%	–	≥ 50th and < 75th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Use of Imaging Studies for Low Back Pain (Ages 65 to 75 years)	43	16	62.8%	47.2%	78.4%	N/A	N/A	73.3%	n.s.	< 10th percentile
Use of Imaging Studies for Low Back Pain (Total)	4,667	1,239	73.5%	72.2%	74.7%	N/A	N/A	75.7%	–	≥ 50th and < 75th percentile
Use of Opioids at High Dosage	1,243	85	6.8%	5.4%	8.3%	7.9%	n.s.	7.9%	n.s.	≥ 25th and < 50th percentile
Use of Opioids From Multiple Providers - Multiple Prescribers	1,542	207	13.4%	11.7%	15.2%	11.5%	n.s.	15.7%	–	≥ 75th and < 90th percentile
Use of Opioids From Multiple Providers - Multiple Pharmacies	1,542	5	0.3%	0.0%	0.6%	0.6%	n.s.	1.4%	–	≥ 90th percentile
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	1,542	2	0.1%	-0.1%	0.3%	0.2%	n.s.	0.8%	–	≥ 90th percentile

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

Prevention and Screening

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

Table 20: Prevention and Screening Measure Descriptions

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

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
OHSU	Developmental Screening in the First Three Years of Life	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Rate 1: On or before the first birthday. Rate 2: On or before the second birthday. Rate 3: On or before the third birthday.	From birth through 1 year of age, 1–2 years, 2–3 years, and total ages
NCQA	Immunizations for Adolescents	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (TDaP) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	The measure calculates a rate for each vaccine and two combination rates. Combination 1 includes the meningococcal and TDaP vaccine, and Combination 2 includes all three vaccinations.	13 years of age
NCQA	Lead Screening in Children	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	N/A	2 years of age
NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 3–17 years, who had an outpatient visit with a primary care physician or obstetrician/gynecologist (ob/gyn), and who had evidence of weight assessment and counseling. Because body mass index (BMI) norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	Rate 1: BMI percentile documentation. Rate 2: Counseling for nutrition. Rate 3: Counseling for physical activity.	Ages 3–11 years, ages 12–17 years, and total ages

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

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

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Childhood Immunization Status - IPV - 4.0 percentage points
  - Colorectal Cancer Screening (Ages 50 to 75 years) - 4.0 percentage points
  - Colorectal Cancer Screening (Total) - 3.1 percentage points
  - Lead Screening in Children - 4.7 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Chlamydia Screening in Women (Ages 16 to 20 years) - 7.9 percentage points
  - Chlamydia Screening in Women (Ages 21 to 24 years) - 5.9 percentage points
  - Chlamydia Screening in Women (Total) - 7.0 percentage points
  - Developmental Screening in the First Three Years of Life - On or Before First Birthday - 29.2 percentage points
  - Developmental Screening in the First Three Years of Life - On or Before Second Birthday - 29.6 percentage points
  - Developmental Screening in the First Three Years of Life - On or Before Third Birthday - 31.0 percentage points
  - Developmental Screening in the First Three Years of Life - Total - 30.0 percentage points
  - Immunizations for Adolescents - HPV - 7.7 percentage points
  - Immunizations for Adolescents - Combination 2 - 7.7 percentage points

Table 21: Prevention and Screening Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Breast Cancer Screening	10,194	5,850	57.4%	56.4%	58.4%	55.3%	+	55.1%	+	≥ 50th and < 75th percentile
Cervical Cancer Screening	407	253	62.2%	57.3%	67.0%	55.4%	n.s.	58.4%	n.s.	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Chlamydia Screening in Women (Ages 16 to 20 years)	6,209	2,827	45.5%	44.3%	46.8%	46.1%	n.s.	53.4%	–	≥ 25th and < 50th percentile
Chlamydia Screening in Women (Ages 21 to 24 years)	5,460	3,043	55.7%	54.4%	57.1%	57.1%	n.s.	61.6%	–	≥ 10th and < 25th percentile
Chlamydia Screening in Women (Total)	11,669	5,870	50.3%	49.4%	51.2%	51.2%	n.s.	57.3%	–	≥ 25th and < 50th percentile
Childhood Immunization Status - Pneumococcal Conjugate	411	324	78.8%	74.8%	82.9%	76.9%	n.s.	75.4%	n.s.	≥ 75th and < 90th percentile
Childhood Immunization Status - DTaP	411	307	74.7%	70.4%	79.0%	72.3%	n.s.	73.3%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - HiB	411	356	86.6%	83.2%	90.0%	83.5%	n.s.	86.3%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - Hepatitis A	411	346	84.2%	80.5%	87.8%	81.3%	n.s.	83.5%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - Hepatitis B	411	379	92.2%	89.5%	94.9%	92.5%	n.s.	89.3%	n.s.	≥ 90th percentile
Childhood Immunization Status - IPV	411	377	91.7%	88.9%	94.5%	91.2%	n.s.	87.7%	+	≥ 90th percentile
Childhood Immunization Status - Influenza	411	175	42.6%	37.7%	47.5%	47.5%	n.s.	45.6%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - MMR	411	356	86.6%	83.2%	90.0%	87.6%	n.s.	86.8%	n.s.	≥ 50th and < 75th percentile
Childhood Immunization Status - Rotavirus	411	309	75.2%	70.9%	79.5%	73.5%	n.s.	71.5%	n.s.	≥ 75th and < 90th percentile
Childhood Immunization Status - VZV	411	357	86.9%	83.5%	90.2%	87.4%	n.s.	86.5%	n.s.	≥ 75th and < 90th percentile
Childhood Immunization Status - Combo 3	411	287	69.8%	65.3%	74.4%	66.7%	n.s.	68.0%	n.s.	≥ 75th and < 90th percentile
Childhood Immunization Status - Combo 7	411	256	62.3%	57.5%	67.1%	56.9%	n.s.	59.1%	n.s.	≥ 75th and < 90th percentile
Childhood Immunization Status - Combo 10	411	140	34.1%	29.4%	38.8%	35.5%	n.s.	36.4%	n.s.	≥ 50th and < 75th percentile
Colorectal Cancer Screening (Ages 50 to 75 years)	22,502	10,721	47.6%	47.0%	48.3%	N/A	N/A	43.6%	+	NA
Colorectal Cancer Screening (Ages 46 to 49 years)	6,840	1,629	23.8%	22.8%	24.8%	N/A	N/A	21.3%	+	NA
Colorectal Cancer Screening (Total)	29,342	12,350	42.1%	41.5%	42.7%	N/A	N/A	39.0%	+	NA
Developmental Screening in the First Three Years of Life - On or Before First Birthday	4,239	1,290	30.4%	29.0%	31.8%	39.6%	–	59.7%	–	NA
Developmental Screening in the First Three Years of Life - On or Before Second Birthday	4,852	1,615	33.3%	31.9%	34.6%	50.8%	–	62.9%	–	NA
Developmental Screening in the First Three Years of Life - On or Before Third Birthday	5,334	1,714	32.1%	30.9%	33.4%	59.1%	–	63.1%	–	NA
Developmental Screening in the First Three Years of Life - Total	14,425	4,619	32.0%	31.3%	32.8%	50.2%	–	62.0%	–	NA
Immunizations for Adolescents - HPV	411	135	32.9%	28.2%	37.5%	33.1%	n.s.	40.5%	–	≥ 25th and < 50th percentile
Immunizations for Adolescents - Meningococcal	411	365	88.8%	85.6%	92.0%	83.9%	+	87.9%	n.s.	≥ 75th and < 90th percentile
Immunizations for Adolescents - TDaP	411	359	87.4%	84.0%	90.7%	84.7%	n.s.	88.2%	n.s.	≥ 50th and < 75th percentile
Immunizations for Adolescents - Combination 1	411	357	86.9%	83.5%	90.2%	82.5%	n.s.	87.0%	n.s.	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Immunizations for Adolescents - Combination 2	411	133	32.4%	27.7%	37.0%	32.4%	n.s.	40.0%	–	≥ 25th and < 50th percentile
Lead Screening in Children	411	356	86.6%	83.2%	90.0%	84.4%	n.s.	81.9%	+	≥ 90th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Ages 3 to 11 years)	216	179	82.9%	77.6%	88.1%	81.6%	n.s.	83.6%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Ages 12 to 17 years)	126	102	81.0%	73.7%	88.2%	74.7%	n.s.	80.8%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	342	281	82.2%	78.0%	86.4%	78.5%	n.s.	82.5%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Ages 3 to 11 years)	216	153	70.8%	64.5%	77.1%	78.4%	n.s.	75.7%	n.s.	≥ 25th and < 50th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Ages 12 to 17 years)	126	94	74.6%	66.6%	82.6%	66.7%	n.s.	71.5%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	342	247	72.2%	67.3%	77.1%	73.1%	n.s.	74.1%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Ages 3 to 11 years)	216	146	67.6%	61.1%	74.1%	73.5%	n.s.	70.3%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Ages 12 to 17 years)	126	95	75.4%	67.5%	83.3%	68.0%	n.s.	72.2%	n.s.	≥ 50th and < 75th percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	342	241	70.5%	65.5%	75.5%	71.0%	n.s.	70.9%	n.s.	≥ 50th and < 75th percentile

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

Respiratory Conditions

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

Table 22: Respiratory Conditions Measure Descriptions

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Appropriate Testing for Pharyngitis	-	Reported as HEDIS-audited measure	This measure assesses the percentage of episodes for members 3 years of age and older for which the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).	N/A	Ages 3–17 years, ages 18–64 years, 65 years of age and older, and total ages

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
NCQA	Asthma Medication Ratio	✓	Reported as HEDIS-audited measure	This measure assesses the percentage of members ages 5–64 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY.	N/A	Ages 5–11 years, ages 12–18 years, ages 19–50 years, ages 51–64 years, and total ages
NCQA	Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	-	Reported as HEDIS-audited measure	This measure assesses the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit on or between January 1 and November 30 of the MY and who were dispensed appropriate medications. The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.	Rate 1: Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. Rate 2: Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.	40 years of age and older
NCQA	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	-	Reported as HEDIS-audited measure	This measure assesses the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.	N/A	40 years of age and older

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

Strengths are identified for MY 2022 Respiratory Conditions performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Asthma Medication Ratio (Ages 5 to 11 years) - 7.0 percentage points
  - Use of Spirometry Testing in the Assessment and Diagnosis of COPD - 4.2 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Appropriate Testing for Pharyngitis (Ages 3 to 17 years) - 7.4 percentage points
  - Asthma Medication Ratio (Ages 19 to 50 years) - 4.5 percentage points
  - Asthma Medication Ratio (Ages 51 to 64 years) - 8.0 percentage points
  - Asthma Medication Ratio (Total) - 3.4 percentage points

Table 23: Respiratory Conditions Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Appropriate Testing for Pharyngitis (Ages 3 to 17 years)	3,868	2,645	68.4%	66.9%	69.9%	73.5%	–	75.7%	–	≥ 10th and < 25th percentile
Appropriate Testing for Pharyngitis (Ages 18 to 64 years)	2,803	1,552	55.4%	53.5%	57.2%	56.3%	n.s.	53.4%	n.s.	≥ 10th and < 25th percentile
Appropriate Testing for Pharyngitis (Ages 65 years and older)	2	0	N/A	N/A	N/A	N/A	N/A	33.3%	N/A	NA
Appropriate Testing for Pharyngitis (Total)	6,673	4,197	62.9%	61.7%	64.1%	65.4%	–	65.5%	–	≥ 10th and < 25th percentile
Asthma Medication Ratio (Ages 5 to 11 years)	490	406	82.9%	79.4%	86.3%	84.7%	n.s.	75.8%	+	≥ 75th and < 90th percentile
Asthma Medication Ratio (Ages 12 to 18 years)	650	474	72.9%	69.4%	76.4%	76.4%	n.s.	72.9%	n.s.	≥ 50th and < 75th percentile
Asthma Medication Ratio (Ages 19 to 50 years)	1,959	1,111	56.7%	54.5%	58.9%	56.9%	n.s.	61.2%	–	≥ 25th and < 50th percentile
Asthma Medication Ratio (Ages 51 to 64 years)	513	280	54.6%	50.2%	59.0%	55.4%	n.s.	62.6%	–	≥ 10th and < 25th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Asthma Medication Ratio (Total)	3,612	2,271	62.9%	61.3%	64.5%	64.2%	n.s.	66.3%	–	≥ 25th and < 50th percentile
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation - Bronchodilator	526	456	86.7%	83.7%	89.7%	87.6%	n.s.	88.3%	n.s.	≥ 50th and < 75th percentile
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation - Systemic Corticosteroid	526	412	78.3%	74.7%	81.9%	81.5%	n.s.	78.3%	n.s.	≥ 75th and < 90th percentile
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	725	200	27.6%	24.3%	30.9%	25.3%	n.s.	23.4%	+	≥ 75th and < 90th percentile

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

Utilization

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

Table 24: Utilization Measure Descriptions

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

Measure Steward	Measure Name	Included in the CMS Core Set	Validation and Reporting	Measure Description	Measure(s) Stratifications Reported, as Applicable	Age Group(s) Reported
AHRQ	Diabetes Short-Term Complications Admission Rate	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries 18 years of age and older. A lower rate indicates better performance.	N/A	Ages 18–64 years and 65 years of age and older
NCQA	Frequency of Selected Procedures	-	Reported as HEDIS-audited measure	This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization. Rates are calculated as a percentage of procedure counts by member months. Neither a higher or a lower rate indicates better performance.	Rate 1: Back surgery. Females ages 20–44 years and ages 45–64 years and males ages 20–44 years and ages 45–64 years Rate 2: Bariatric weight loss surgery. Females ages 0–19 years, 20–44 years, and 45–64 years and males ages 0–19 years and 20–44 years. Rate 3: Cholecystectomy laparoscopic. Females ages 15–44 years and 45–64 years and males ages 30–64 years. Rate 4: Cholecystectomy open. Females ages 15–44 years and 45–64 years and males ages 30–64 years. Rate 5: Hysterectomy abdominal. Females ages 15–44 years and ages 45–64 years. Rate 6: Hysterectomy vaginal. Females ages 15–44 years and ages 45–64 years. Rate 7: Lumpectomy. Females ages 15–44 years and ages 45–64 years. Rate 8: Mastectomy. Females ages 15–44 years and ages 45–64 years. Rate 9: Tonsillectomy. Females and males ages 0–9 years and ages 10–19 years.	Age groups vary by the measure stratifications
AHRQ	Heart Failure Admission Rate	✓	Measure is calculated by the MCO and validated by IPRO	This measure assesses the number of discharges for heart failure in adults 18 years of age and older per 100,000 Medicaid member months. A lower rate indicates better performance.	N/A	Ages 18–64 years, 65 years of age and older, and 18 years of age and older
NCQA	Inpatient Utilization	-	Reported as HEDIS-audited measure	This measure summarizes utilization of acute inpatient care and services. Data are reported for the index hospital stays as: average length of stay, days per 1,000 member years, and discharges per 1,000 member years.	Rate 1: Maternity. Age cohorts: ages 10–19 years, 20–44 years, 45–64 years, and total age groups Rate 2: Surgery. Age cohorts: ages 1–9 years, 10–19 years, 20–44 years, 45–64 years, and total age groups Rate 3: Medicine. Age cohorts: ages 1–9 years, 10–19 years, 20–44 years, 45–64 years, and total age groups Rate 4: Total inpatient (the sum of maternity, surgery and medicine). Age cohorts: ages 1–9 years, 10–19 years, 20–44 years, 45–64 years, and total age groups	Age groups vary by the measure stratifications
NCQA	Well-Child Visits in the First 30 Months of Life	✓	Reported as HEDIS audited measure	This measure assesses the percentage of members who turned 30 months old during the MY and who were continuously enrolled from 31 days of age through 30 months of age.	Rate 1: Received six or more well-child visits with a primary care physician during their first 15 months of life. Rate 2: Received two or more well-child visits for ages 15–30 months of life.	30 months of age
NCQA	Plan All-Cause Readmissions	✓	Reported as HEDIS-audited measure	The measure assesses, for members ages 18–64 years, the number of acute inpatient and observation stays during the MY that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported for the total index hospital stays. Data are reported for the total index hospital stays in the following categories: count of index hospital stays (IHS; denominator); count of 30-day readmissions (numerator); observed readmission rate; expected readmissions rate; and observed-to-expected readmission ratio.	N/A	Ages 18–44 years, ages 45–54 years, ages 55–64 years, and total ages

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

Strengths are identified for MY 2022 Utilization performance measures.

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages less than 1 year) - 37.4 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages less than 1 year) - 37.6 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 1 to 9 years) - 372.7 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 10 to 19 years) - 433.5 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 20 to 44 years) - 233.7 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Total) - 163.4 percentage points
  - Antibiotic Utilization for Respiratory Conditions (Ages 3 months to 17 years) - 5.0 percentage points
  - Antibiotic Utilization for Respiratory Conditions (Ages 18 to 64 years) - 5.3 percentage points
  - Antibiotic Utilization for Respiratory Conditions (Total) - 5.2 percentage points
  - Asthma in Younger Adults Admission Rate (Age 2 to 17 years) per 100,000 member months – 11.6 Admissions per 100,000 member months
  - Asthma in Younger Adults Admission Rate (Age 2 to 39 years) per 100,000 member months – 6.3 Admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years) per 100,000 member months – 10.2 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 – 48.4 Admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 years and older) per 100,000 member months – 12.9 Admissions per 100,000 member months
  - Heart Failure Admission Rate (Ages 18 to 64 years) per 100,000 member months – 7.4 Admissions per 100,000 member months
  - Heart Failure Admission Rate (Age 65 years and older) per 100,000 member months – 135.5 Admissions per 100,000 member months
  - Heart Failure Admission Rate (Age 18 years and older) per 100,000 member months – 10.4 Admissions per 100,000 member months

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Diabetes Short-Term Complications Admission Rate (Age 65 years and older) per 100,000 member months – 8.6 Admissions per 100,000 member months
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 1 to 9 years) - 28.3 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 20 to 44 years) - 64.6 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 45 to 64 years) - 108.2 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 65 to 74 years) - 196.2 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 75 to 84 years) - 315.7 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 85 years and older) - 231.1 Visits per 1,000 member years
  - Ambulatory Care - Emergency Dept Visits per 1,000 member years (Total) - 49.4 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 45 to 64 years) - 54.2 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 65 to 74 years) - 4220.9 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 75 to 84 years) - 4953.2 Visits per 1,000 member years
  - Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 85 years and older) - 6610.1 Visits per 1,000 member years

Table 25: Utilization Measure Data

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages less than 1 year)[3]	64,373	6,016	1121.5	N/A	N/A	850.9	+	1084.1	+	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 1 to 9 years)[3]	670,496	28,447	509.1	N/A	N/A	400.7	+	537.4	-	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 10 to 19 years)[3]	707,322	23,914	405.7	N/A	N/A	379.0	+	406.6	-	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 20 to 44 years)[3]	1,190,875	66,513	670.2	N/A	N/A	751.9	-	734.8	-	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 45 to 64 years)[3]	518,938	24,572	568.2	N/A	N/A	611.5	-	676.5	-	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 65 to 74 years)[3]	7,431	233	376.3	N/A	N/A	400.0	-	572.5	-	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 75 to 84 years)[3]	2,438	58	285.5	N/A	N/A	315.2	-	601.2	-	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages 85 years and older)[3]	632	17	322.8	N/A	N/A	364.4	-	553.8	-	NA
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Total)[3]	3,162,505	149,770	568.3	N/A	N/A	567.1	+	617.7	-	≥ 25th and < 50th percentile
Ambulatory Care - Emergency Dept Visits per 1,000 member years (Ages unknown)[3]	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages less than 1 year)[3]	64,373	48,964	9127.6	N/A	N/A	8957.0	+	9090.0	+	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 1 to 9 years)[3]	670,496	212,386	3801.1	N/A	N/A	3371.2	+	3428.4	+	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 10 to 19 years)[3]	707,322	191,740	3253.0	N/A	N/A	3219.8	+	2819.5	+	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 20 to 44 years)[3]	1,190,875	382,872	3858.1	N/A	N/A	4326.6	-	3624.4	+	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 45 to 64 years)[3]	518,938	266,443	6161.3	N/A	N/A	6735.5	-	6215.5	-	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 65 to 74 years)[3]	7,431	3,263	5269.3	N/A	N/A	6124.1	-	9490.2	-	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 75 to 84 years)[3]	2,438	1,080	5315.8	N/A	N/A	6211.2	-	10269.0	-	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages 85 years and older)[3]	632	199	3778.5	N/A	N/A	4138.8	-	10388.6	-	NA
Ambulatory Care - Outpatient Visits per 1,000 member years (Total)[3]	3,162,505	1,106,947	4200.3	N/A	N/A	4366.6	-	4036.9	+	≥ 50th and < 75th percentile
Ambulatory Care - Outpatient Visits per 1,000 member years (Ages unknown)[3]	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
Antibiotic Utilization for Respiratory Conditions (Ages 3 months to 17 years)	109,142	25,983	23.8%	23.6%	24.1%	N/A	N/A	18.8%	+	NA
Antibiotic Utilization for Respiratory Conditions (Ages 18 to 64 years)	89,025	19,185	21.6%	21.3%	21.8%	N/A	N/A	16.2%	+	NA
Antibiotic Utilization for Respiratory Conditions (Ages 65 years and older)	209	27	12.9%	8.1%	17.7%	N/A	N/A	14.1%	n.s.	NA
Antibiotic Utilization for Respiratory Conditions (Total)	198,376	45,195	22.8%	22.6%	23.0%	N/A	N/A	17.6%	+	NA
Asthma in Younger Adults Admission Rate (Age 2 to 17 years) per 100,000 member months	1,173,445	46	3.9	N/A	N/A	4.7	-	15.5	-	NA
Asthma in Younger Adults Admission Rate (Age 18 to 39 years) per 100,000 member months	1,139,281	49	4.3	N/A	N/A	5.0	n.s.	5.1	n.s.	NA
Asthma in Younger Adults Admission Rate (Total Age 2 to 39 years) per 100,000 member months	2,312,726	95	4.1	N/A	N/A	4.8	-	10.4	-.	NA
Child and Adolescent Well-Care Visits (Ages 3 to 11 years)	48,014	31,229	65.0%	64.6%	65.5%	63.1%	+	66.3%	-	≥ 75th and < 90th percentile
Child and Adolescent Well-Care Visits (Ages 12 to 17 years)	30,865	17,847	57.8%	57.3%	58.4%	56.7%	+	59.9%	-	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Child and Adolescent Well-Care Visits (Ages 18 to 21 years)	18,210	6,252	34.3%	33.6%	35.0%	33.2%	+	35.9%	-	≥ 75th and < 90th percentile
Child and Adolescent Well-Care Visits (Total)	97,089	55,328	57.0%	56.7%	57.3%	55.6%	+	58.9%	-	≥ 75th and < 90th percentile
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 40 to 64 years) per 100,000 member months	706,199	161	22.8	N/A	N/A	27.4	-	33.2	-	NA
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months	10,558	4	37.9	N/A	N/A	65.9	-	86.3	-	NA
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 years and older) per 100,000 member months	716,757	165	23.0	N/A	N/A	27.9	-	35.9	-	NA
Diabetes Short-Term Complications Admission Rate (Ages 18-64 years) per 100,000 member months	1,845,480	277	15.0	N/A	N/A	18.6	-	16.3	-	NA
Diabetes Short-Term Complications Admission Rate (Age 65 years and older) per 100,000 member months	10,558	2	18.9	N/A	N/A	13.2	+	10.3	+	NA
Diabetes Short-Term Complications Admission Rate (Age 18 years and older) per 100,000 member months	1,856,038	279	15.0	N/A	N/A	18.6	-	16.2	-	NA
Frequency of Selected Procedures - Back Surgery (Females ages 20 to 44 years)	698,870	99	1.7	1.7	1.7	1.9	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Back Surgery (Females ages 45 to 64 years)	288,923	140	5.8	5.7	5.9	6.8	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Back Surgery (Males ages 20 to 44 years)	491,950	81	2.0	1.9	2.0	2.4	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Back Surgery (Males ages 45 to 64 years)	230,003	128	6.7	6.6	6.8	7.1	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 0 to 19 years)	691,726	2	0.0	0.0	0.0	0.1	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 20 to 44 years)	698,870	213	3.7	3.6	3.7	2.8	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Females ages 45 to 64 years)	288,923	73	3.0	3.0	3.1	3.1	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 0 ages 19 years)	750,454	1	0.0	0.0	0.0	0.0	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 20 and 44 years)	491,950	25	0.6	0.6	0.6	0.4	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Bariatric Weight Loss Surgery (Males ages 45 to 64 years)	230,003	15	0.8	0.7	0.8	0.4	N/A	N/A	N/A	≥ 75th and < 90th percentile

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 15 to 44 years)	864,549	480	6.7	6.6	6.7	7.7	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Females ages 45 to 64 years)	288,923	142	5.9	5.8	6.0	7.7	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Cholecystectomy Laparoscopic (Males ages 30 to 64 years)	504,232	116	2.8	2.7	2.8	3.1	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Cholecystectomy Open (Females ages 15 to 44 years)	864,549	4	0.1	0.1	0.1	0.0	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Cholecystectomy Open (Females ages 45 to 64 years)	288,923	5	0.2	0.2	0.2	0.2	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Cholecystectomy Open (Males ages 30 to 64 years)	504,232	10	0.2	0.2	0.3	0.1	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 15 to 44 years)	864,549	51	0.7	0.7	0.7	0.7	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Hysterectomy Abdominal (Ages 45 to 64 years)	288,923	35	1.5	1.4	1.5	1.7	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 15 to 44 years)	864,549	37	0.5	0.5	0.5	0.7	N/A	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Hysterectomy Vaginal (Ages 45 to 64 years)	288,923	19	0.8	0.8	0.8	0.6	N/A	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Lumpectomy (Females ages 15 to 44 years)	864,549	90	1.3	1.2	1.3	1.1	N/A	N/A	N/A	≥ 75th and < 90th percentile
Frequency of Selected Procedures - Lumpectomy (Females ages 45 to 64 years)	288,923	70	2.9	2.8	3.0	3.5	N/A	N/A	N/A	≥ 25th and < 50th percentile
Frequency of Selected Procedures - Mastectomy (Females ages 15 to 44 years)	864,549	42	0.6	0.6	0.6	0.8	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Mastectomy (Females ages 45 to 64 years)	288,923	37	1.5	1.5	1.6	2.3	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Tonsillectomy (Males and Females ages 0 to 9 years)	734,869	319	5.2	5.2	5.3	3.0	N/A	N/A	N/A	≥ 50th and < 75th percentile
Frequency of Selected Procedures - Tonsillectomy (Males and Females ages 10 to 19 years)	707,322	128	2.2	2.1	2.2	1.7	N/A	N/A	N/A	≥ 50th and < 75th percentile
Heart Failure Admission Rate (Ages 18 to 64 years) per 100,000 member months	1,845,480	230	12.5	N/A	N/A	18.3	-	19.9	-	NA
Heart Failure Admission Rate (Age 65 years and older) per 100,000 member months	10,558	4	37.9	N/A	N/A	79.1	-	17.3	-	NA
Heart Failure Admission Rate (Age 18 years and older) per 100,000 member months	1,856,038	234	12.6	N/A	N/A	18.6	-	23.0	-	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	326	845	2.6	0.7	4.5	32.9	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	4,109	10,117	2.5	2.0	2.9	30.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	8	42	5.3	N/A	N/A	24.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Average Length of Stay (ALOS) (Total)[3]	4,443	11,004	2.5	2.0	2.9	30.2	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	845	14.3	14.3	14.4	19.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	10,117	102.0	N/A	N/A	121.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	42	1.0	0.9	1.0	0.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Days per 1,000 Member Years (Total)[3]	2,417,135	11,004	54.6	54.6	54.7	64.2	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	326	5.5	5.5	5.6	7.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	4,109	41.4	41.3	41.5	48.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	8	0.2	0.2	0.2	0.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Maternity Discharges per 1,000 Member Years (Total)[3]	2,417,135	4,443	22.1	22.0	22.1	25.4	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages less than 1 year)[3]	454	2,503	5.5	3.3	7.7	61.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 1 to 9 years)[3]	823	3,447	4.2	2.8	5.6	34.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	622	2,069	3.3	1.8	4.8	44.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	2,705	9,549	3.5	2.8	4.2	44.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	3,670	15,232	4.2	3.5	4.8	51.0	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 65 to 74 years)[3]	59	460	7.8	0.1	15.5	66.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 75 to 84 years)[3]	18	57	3.2	N/A	N/A	72.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Ages 85 years and older)[3]	6	59	9.8	N/A	N/A	40.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Average Length of Stay (ALOS) (Total)[3]	8,357	33,376	4.0	3.6	4.4	47.6	N/A	N/A	N/A	≥ 10th and < 25th percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages less than 1 year)[3]	64,373	2,503	466.6	N/A	N/A	385.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 1 to 9 years)[3]	670,496	3,447	61.7	61.6	61.8	32.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	2,069	35.1	35.0	35.2	40.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	9,549	96.2	96.2	96.3	116.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	15,232	352.2	N/A	N/A	411.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 65 to 74 years)[3]	7,431	460	742.8	N/A	N/A	455.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 75 to 84 years)[3]	2,438	57	280.6	N/A	N/A	681.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Ages 85 years and older)[3]	632	59	1120.3	N/A	N/A	520.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Days per 1,000 Member Years (Total)[3]	3,162,505	33,376	126.6	N/A	N/A	136.1	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages less than 1 year)[3]	64,373	454	84.6	84.4	84.9	75.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 1 to 9 years)[3]	670,496	823	14.7	14.6	14.8	11.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	622	10.6	10.5	10.6	11.0	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	2,705	27.3	27.2	27.3	31.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	3,670	84.9	84.8	85.0	96.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 65 to 74 years)[3]	7,431	59	95.3	94.8	95.8	82.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 75 to 84 years)[3]	2,438	18	88.6	87.3	89.9	113.5	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Ages 85 years and older)[3]	632	6	113.9	N/A	N/A	156.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Medicine Discharges per 1,000 Member Years (Total)[3]	3,162,505	8,357	31.7	31.7	31.8	34.3	N/A	N/A	N/A	≥ 50th and < 75th percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages less than 1 year)[3]	68	1,065	15.7	6.3	25.0	142.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 1 to 9 years)[3]	197	1,154	5.9	2.3	9.4	119.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	286	1,666	5.8	2.9	8.7	69.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	1,396	7,661	5.5	4.3	6.7	65.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	1,648	10,856	6.6	5.4	7.8	79.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 65 to 74 years)[3]	23	168	7.3	N/A	N/A	78.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 75 to 84 years)[3]	5	33	6.6	N/A	N/A	42.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Ages 85 years and older)[3]	3	6	2.0	N/A	N/A	192.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Average Length of Stay (ALOS) (Total)[3]	3,626	22,609	6.2	5.4	7.0	77.3	N/A	N/A	N/A	< 10th percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages less than 1 year)[3]	64,373	1,065	198.5	N/A	N/A	165.0	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 1 to 9 years)[3]	670,496	1,154	20.7	20.6	20.7	35.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	1,666	28.3	28.2	28.4	25.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	7,661	77.2	77.1	77.3	78.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	10,856	251.0	N/A	N/A	265.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 65 to 74 years)[3]	7,431	168	271.3	N/A	N/A	298.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 75 to 84 years)[3]	2,438	33	162.4	N/A	N/A	88.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Ages 85 years and older)[3]	632	6	113.9	N/A	N/A	416.5	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Days per 1,000 Member Years (Total)[3]	3,162,505	22,609	85.8	85.8	85.8	90.0	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages less than 1 year)[3]	64,373	68	12.7	12.4	12.9	13.9	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 1 to 9 years)[3]	670,496	197	3.5	3.5	3.6	3.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	286	4.9	4.8	4.9	4.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	1,396	14.1	14.0	14.1	14.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	1,648	38.1	38.0	38.2	40.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 65 to 74 years)[3]	7,431	23	37.1	36.0	38.2	46.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 75 to 84 years)[3]	2,438	5	24.6	22.9	26.3	25.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Ages 85 years and older)[3]	632	3	57.0	53.0	60.9	26.0	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Surgery Discharges per 1,000 Member Years (Total)[3]	3,162,505	3,626	13.8	13.7	13.8	13.9	N/A	N/A	N/A	≥ 50th and < 75th percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages less than 1 year)[3]	522	3,568	6.8	4.6	9.1	73.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 1 to 9 years)[3]	1,020	4,601	4.5	3.2	5.8	54.5	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 10 to 19 years)[3]	1,234	4,580	3.7	2.6	4.8	45.5	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 20 to 44 years)[3]	8,210	27,327	3.3	2.9	3.7	40.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 45 to 64 years)[3]	5,326	26,130	4.9	4.3	5.5	59.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 65 to 74 years)[3]	82	628	7.7	1.3	14.0	70.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 75 to 84 years)[3]	23	90	3.9	N/A	N/A	66.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Ages 85 years and older)[3]	9	65	7.2	N/A	N/A	61.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Average Length of Stay (ALOS) (Total)[3]	16,426	66,989	4.1	3.8	4.4	48.8	N/A	N/A	N/A	≥ 10th and < 25th percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages less than 1 year)[3]	64,373	3,568	665.1	N/A	N/A	550.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 1 to 9 years)[3]	670,496	4,601	82.4	82.3	82.4	67.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	4,580	77.7	77.6	77.8	85.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	27,327	275.4	N/A	N/A	316.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	26,130	604.2	N/A	N/A	677.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years(Ages 65 to 74 years)[3]	7,431	628	1014.1	N/A	N/A	754.1	N/A	N/A	N/A	NA

Indicator Name	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2021 Rate	MY 2022 Rate Compared to MY 2021[1]	MY 2022 MMC	MY 2022 Rate Compared to MMC[2]	HEDIS MY 2022 Percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 75 to 84 years)[3]	2,438	90	443.0	N/A	N/A	769.3	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Ages 85 years and older)[3]	632	65	1234.2	N/A	N/A	937.1	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Days per 1,000 Member Years (Total)[3]	3,162,505	66,989	254.2	N/A	N/A	274.4	N/A	N/A	N/A	≥ 25th and < 50th percentile
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages less than 1 year)[3]	64,373	522	97.3	97.2	97.4	89.6	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 1 to 9 years)[3]	670,496	1,020	18.3	18.2	18.4	14.9	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 10 to 19 years)[3]	707,322	1,234	20.9	20.8	21.0	22.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 20 to 44 years)[3]	1,190,875	8,210	82.7	82.7	82.8	94.4	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 45 to 64 years)[3]	518,938	5,326	123.2	N/A	N/A	137.0	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 65 to 74 years)[3]	7,431	82	132.4	N/A	N/A	128.8	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 75 to 84 years)[3]	2,438	23	113.2	N/A	N/A	138.7	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Ages 85 years and older)[3]	632	9	170.9	N/A	N/A	182.2	N/A	N/A	N/A	NA
Inpatient Utilization - General Hospital/Acute Care - Total Inpatient Discharges per 1,000 Member Years (Total)[3]	3,162,505	16,426	62.3	62.3	62.4	67.4	N/A	N/A	N/A	≥ 50th and < 75th percentile
Well-Child Visits in the First 30 Months of Life (First 15 Months)	4,453	2,940	66.0%	64.6%	67.4%	65.2%	n.s.	68.1%	-	≥ 75th and < 90th percentile
Well-Child Visits in the First 30 Months of Life (15 Months to 30 Months)	5,036	3,794	75.3%	74.1%	76.5%	73.9%	n.s.	74.0%	+	≥ 75th and < 90th percentile

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

Table 26: Plan-All Cause Readmissions

Age Group	Count of Index Hospital Stays (IHS)—Total Stays	Count of Observed 30-Day Readmissions —Total Stays	Observed Readmission Rate - Total Stays[1]	Count of Expected 30-Day Readmissions —Total Stays	Expected Readmission Rate - Total Stays[2]	MY 2022 Observed to Expected Readmission Ratio - Total Stays[3]	MY 2021 Observed to Expected Remission Ratio - Total Stays[3]
Ages 18 to 44 years	2,923	201	6.9%	243.5	8.3%	0.8	0.7
Ages 45 to 54 years	1,421	112	7.9%	144.1	10.1%	0.8	0.7
Ages 55 to 64 years	1,753	152	8.7%	206.9	11.8%	0.7	0.7
Ages 18 to 64 years	6,097	465	7.6%	594.5	9.8%	0.8	0.7

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

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

Objectives

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

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

Technical Methods of Data Collection and Analysis

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO's compliance status with regard to the SMART items. For example, all provisions relating to availability of services are summarized under *Title 42 CFR § 438.206 Availability of services*. This grouping process was done by referring to CMS's "Regulations Subject to Compliance Review," where specific Medicaid regulations are noted as required for review and corresponding sections are identified and described for each Subpart, particularly D and E. Each item was assigned a value of "Compliant" or "Non-compliant" in the item log submitted by DHS. If an item was not evaluated for a particular MCO, it was assigned a value of "Not Determined." Compliance with the BBA requirements was then determined based on the aggregate results of the SMART items linked to each provision within a requirement or category. If all items were Compliant, the MCO was evaluated as Compliant. If some were Compliant and some were Non-compliant, the MCO was evaluated as Partially Compliant. If all items were Non-compliant, the MCO was evaluated as Non-compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined was assigned for that category.

Categories determined to be Partially Compliant or Non-compliant are indicated where applicable in the tables below, and the SMART items that were assigned a value of Non-compliant by DHS within those categories are noted. For GEI, there were no categories determined to be Partially Compliant or Non-compliant, signifying that no SMART items were assigned a value of Non-compliant by DHS. There are therefore no recommendations related to compliance with structure and operations standards for GEI for the current review year.

Description of Data Obtained

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the subparts set out in the BBA regulations and described in CMS's *Protocol 3: Review of Compliance with*

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

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

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

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

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

Table 27: SMART Items Count Per Regulation

BBA Regulation	SMART Items	Required	Related
Subpart B: State Responsibilities			
Disenrollment Requirements	1	✓	-
Subpart C: Enrollee Rights and Protections			
Enrollee Rights	7	-	✓
Provider-Enrollee Communication	1	-	✓

BBA Regulation	SMART Items	Required	Related
Marketing Activities	2	-	✓
Cost Sharing	0	-	-
Emergency and Post-Stabilization Services	5	✓	-
Subpart D: MCO, PIHP, and PAHP Standards			
Availability of Services	14	✓	-
Assurances of Adequate Capacity and Services	3	✓	-
Coordination and Continuity of Care	13	✓	-
Coverage and Authorization of Services	9	✓	-
Provider Selection	4	✓	-
Provider Discrimination Prohibited	1	✓	-
Confidentiality	1	✓	-
Grievance and Appeal System	1	✓	-
Subcontractual Relationships and Delegations	3	✓	-
Practice Guidelines	2	✓	-
Health Information Systems	18	✓	-
Subpart E: Quality Measurement and Improvement; External Quality Review			
QAPI Program	9	✓	-
Subpart F: Grievance and Appeal System			
General Requirements	8	-	✓
Notice of Action	3	-	✓
Handling of Grievances and Appeals	9	-	✓
Resolution and Notification	7	-	✓
Expedited Resolution	4	-	✓
Information to Providers and Subcontractors	1	-	✓
Recordkeeping and Recording	6	-	✓
Continuation of Benefits Pending Appeal and State Fair Hearings	2	-	✓
Effectuation of Reversed Resolutions	0	-	✓

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

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

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

Conclusions and Comparative Findings

Of the 134 SMART items, 88 items were evaluated and 47 were not evaluated for the MCO in 2022, 2021, or 2020. For categories where items were not evaluated for compliance for 2022, results from reviews conducted within the two prior years (2021 and 2020) were evaluated to determine compliance, if available. Given that the MCO was found to be compliant on all SMART items across Subparts C, D, E, and F, there are no recommendations for the MCO for MY 2022.

Subpart B: State Responsibilities

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

Table 28: GEI Compliance with State Responsibilities

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

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

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this category is to ensure that each MCO had written policies regarding enrollee rights and complies with applicable federal and state laws that pertain to enrollee rights, and that the MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to Members (*Title 42 CFR § 438.100 (a)−(b)*). The SMART database and DHS's audit document information include assessment of the MCO's compliance with regulations found in Subpart C. **Table 29** presents the findings by categories consistent with the regulations.

Table 29: GEI Compliance with Enrollee Rights and Protections Regulations

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

MCO: managed care organization.

GEI was evaluated against 13 of the 15 SMART items crosswalked to Enrollee Rights and Protections regulations and was compliant on all 13 items. GEI was found to be compliant on all eight of the categories of Enrollee Rights and Protections regulations. GEI was found to be compliant on the Cost Sharing provision, based on the HealthChoices Agreement.

Subpart D: MCO, PIHP, and PAHP Standards

The general purpose of the regulations included under this heading is to ensure that all services available under the commonwealth's Medicaid managed care program are available and accessible to GEI Members (*Title 42 CFR § 438.206 (a)*). The SMART database includes an assessment of the MCO's compliance with regulations found in Subpart D. For the category of Assurances of Adequate Capacity and Services, the MCO was evaluated as noted above against additional SMART items and DHS monitoring activities. **Table 30** presents the findings by categories consistent with the regulations.

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

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

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

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

GEI was evaluated against 53 of 71 SMART items that were crosswalked to MCO, PIHP, and PAHP Standards regulations and was compliant on 53 items. Of the 12 categories in MCO, PIHP, and PAHP Standards, GEI was found to be compliant in 12 categories.

Subpart E: Quality Measurement and Improvement; External Quality Review

The general purpose of the regulations included under this heading is to ensure that managed care entities establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement Program for the services it furnishes to its Medicaid Members (*Title 42 CFR § 438.330*). The MCO's compliance with the regulation found in Subpart E was evaluated as noted above against additional SMART items and DHS monitoring activities. **Table 31** presents the findings by categories consistent with the regulation.

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

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

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

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

Subpart F: Grievance and Appeal System

The general purpose of the regulations included under this heading is to ensure that Members have the ability to pursue grievances. The SMART database and DHS's audit document information include assessment of the MCO's compliance with regulations found in Subpart F. **Table 32** presents the findings by categories consistent with the regulations.

Table 32: GEI Compliance with Grievance and Appeal System Regulations

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

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

GEI was evaluated against 13 of the 40 SMART items crosswalked to the Grievance and Appeal System and was compliant on all 13 items. GEI was found to be compliant for all nine categories of the Grievance and Appeal System. For the category of Effectuation of Reversed Resolutions, per the NCQA website, the plan has a status of Provisional - Under Corrective Action.

Accreditation Status

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

V. Validation of Network Adequacy

Objectives

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

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

Table 33: Network Adequacy Validation Activities

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

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

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

Technical Methods of Data Collection and Analysis

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

Description of Data Obtained

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

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

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

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

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

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

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

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

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

Conclusions and Comparative Findings

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

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

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

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

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Table 35: CAHPS Categories and Response Options

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

CAHPS: Consumer Assessment of Healthcare Providers and Systems.

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

Description of Data Obtained

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

Conclusions and Comparative Findings

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

Table 36: CAHPS MY 2022 Adult Survey Results

Survey Section/Measure	MY 2022	MY 2022 Rate Compared to MY 2021	MY 2021	MY 2021 Rate Compared to MY 2020	MY 2020	MY 2022 MMC Weighted Average
Your health plan						
Satisfaction with Adult’s Health Plan (Rating of 8–10)	83.66%	▲	75.38%	▼	85.71%	81.33%
Getting Needed Information (Usually or Always)	84.48%	▼	91.84%	▲	88.54%	84.33%
Your health care in the last 6 months						
Satisfaction with Health Care (Rating of 8–10)	75.52%	▼	76.22%	▼	80.47%	78.54%
Appointment for Routine Care When Needed (Usually or Always)	84.38%	▲	84.25%	▼	85.45%	81.49%

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

Table 37: CAHPS MY 2022 Child Survey Results

Survey Section/Measure	MY 2022	MY 2022 Rate Compared to MY 2021	MY 2021	MY 2021 Rate Compared to MY 2020	MY 2020	MY 2022 MMC Weighted Average
Your child's health plan						
Satisfaction with Child's Health Plan (Rating of 8–10)	86.60%	▼	90.23%	▲	88.42%	88.80%
Information or Help from Customer Service (Usually or Always)	90.20%	▼	91.30%	▲	86.54%	83.06%
Your healthcare in the last 6 months						
Satisfaction with Health Care (Rating of 8–10)	87.14%	▼	89.80%	▲	89.74%	87.10%
Appointment for Routine Care When Needed (Usually or Always)	87.12%	▲	82.98%	▼	89.10%	84.91%

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

VII. MCO Responses to the Previous EQR Recommendations

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

Current and Proposed Interventions

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

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

- follow-up actions that the MCO has taken through June 30, 2023, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the MCO’s process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the response submitted to IPRO as of September 2023, as well as any additional relevant documentation provided by GEI.

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

GEI 2022 Opps
Response Request Fo

Root Cause Analysis and Action Plan

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

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

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

Root_Cause_Analysis_
GEI_Response_Form_C

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

GEI Response to Previous EQR Recommendations

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

Table 38: GEI Response to Previous EQR Recommendations

Recommendation for GEI	IPRO Assessment of MCO Response[1]
Improve Childhood Immunizations Status (Combination 10)	Partially addressed
Improve Body Mass Index: Percentile (Ages 12–17 years)	Partially addressed
Improve Body Mass Index: Percentile (Total)	Partially addressed
Improve Counseling for Nutrition (Ages 12–17 years)	Addressed
Improve Counseling for Nutrition (Total)	Addressed
Improve Counseling for Physical Activity (Ages 12–17 years)	Addressed
Improve Developmental Screening in the First Three Years of Life – Total	Remains an opportunity for improvement
Improve Developmental Screening in the First Three Years of Life – 1 year	Remains an opportunity for improvement
Improve Developmental Screening in the First Three Years of Life – 2 years	Remains an opportunity for improvement
Improve Developmental Screening in the First Three Years of Life – 3 years	Remains an opportunity for improvement
Improve Annual Dental Visit (Ages 2–20 years)	Addressed
Improve Annual Dental Visits for Members with Developmental Disabilities (Ages 2–20 years)	Addressed
Improve Cervical Cancer Screening (Ages 21–64 years)	Addressed
Improve Chlamydia Screening in Women (Ages 16–20 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Ages 21–24 years)	Remains an opportunity for improvement
Improve Chlamydia Screening in Women (Total)	Remains an opportunity for improvement
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 3 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 15–20 years)	Addressed
Improve Contraceptive Care for Postpartum Women: LARC – 3 days (Ages 15–20 years)	Partially addressed
Improve Contraceptive Care for Postpartum Women: LARC – 60 days (Ages 15–20 years)	Addressed

Recommendation for GEI	IPRO Assessment of MCO Response[1]
Improve Contraceptive Care for Postpartum Women: Most or moderately effective contraception – 60 days (Ages 21 to 44 years)	Remains an opportunity for improvement
Improve Prenatal Smoking Cessation	Remains an opportunity for improvement
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 months–17 years)	Partially addressed
Improve Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	Partially addressed
Improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Ages 65 years and older) Admissions per 100,000 member months	Partially addressed

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

EQR: external quality review; MCO: managed care organization; LARC: long-acting reversible contraception.

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

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

GEI Strengths, Opportunities for Improvement, and EQR Recommendations

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

EQR Activity		Quality	Timeliness	Access
Strengths				
PIP: Preventing Inappropriate Use or Overuse of Opioids	GEI's baseline proposal demonstrated that the topic reflects high-volume/high-risk conditions for the population. The MCO's study design specifies data collection methodologies that are valid and reliable, along with robust data analysis procedures. GEI sustained improvement in most indicators from baseline to final measurement.	✓	✓	✓
PIP: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	GEI's baseline proposal for this PIP topic included baseline rates with the potential for meaningful impact on member health, functional status, and satisfaction for the population. The aims and objectives statements that the MCO provided specified performance indicators for improvement with corresponding goals.	✓	✓	✓
Performance Measures	GEI reported measures that were statistically significantly better/above the MY 2022 MMC weighted average by at least three percentage points in the Access to/Availability of Care, Behavioral Health, Diabetes, Maternal and Perinatal Health, Prevention and Screening, Respiratory Conditions, and Utilization categories.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	The MCO was found to be compliant on all Systematic Monitoring, Access, and Retrieval Technology (SMART) items across Subparts C, D, E, and F.	✓	✓	✓
Quality-of-Care Surveys	GEI improved on two of the four adult survey composite scores.	✓	✓	✓
Opportunities				
PIP: Preventing Inappropriate Use or Overuse of Opioids	An opportunity exists to ensure each performance indicator should be addressed by a statement, or summary statements, of aims and objectives. Moreover, the interventions and intervention tracking measures (ITMs) lacked clarity, focus, and detail.	✓	✓	✓

EQR Activity		Quality	Timeliness	Access
PIP: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	An opportunity exists to develop more robust interventions and ITMs. The lack of clarity, focus, and detail in interventions and ITMs, coupled with the absence of a comprehensive discussion on how interventions contributed to the success of performance indicators, made it challenging to determine the specific impact of interventions. Additionally, disease prevalence, baseline, and benchmarks were not adequately addressed.	✓	✓	✓
Performance Measures	GEI reported measures that were statistically significantly worse/below the MY 2022 MMC weighted average by at least three percentage points in the Access to/Availability of Care, Behavioral Health, Diabetes, Maternal and Perinatal Health, Overuse/Appropriateness, Prevention and Screening, and Utilization categories.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	There were no opportunities identified.	-	-	-
Quality-of-Care Surveys	Two of the four adult survey composite scores declined, and three of the four child survey composite scores declined.	✓	✓	✓
Recommendations				
PIP: Preventing Inappropriate Use or Overuse of Opioids	Future PIP submissions should focus on articulating an aim statement and objectives that align with each performance indicator, addressing recurrent, detailed barrier analysis, and modification of low-performing interventions. The barrier analysis should include an examination of race and ethnicity barriers.	✓	-	✓
PIP: Reducing Potentially Preventable Hospital Admissions, Readmissions and ED Visits	Future PIP submissions should focus on articulating an aim statement and objectives that align with each performance indicator, addressing recurrent, detailed barrier analysis, and modification of low-performing interventions. GEI should interpret performance indicator rates using ITM data, providing insights into the degree of goal achievement and address factors associated with success or failure, including ITM rates, documented findings from barrier analysis, and modifications to interventions. Future submissions should consider internal and external threats to validity.	✓	-	-
Performance Measures	It is recommended that GEI work to improve access to and availability of care for both dental visits and preventive ambulatory health services for adults 65 years of age and older.	✓	-	✓

EQR Activity		Quality	Timeliness	Access
Performance Measures	It is recommended that GEI work to improve behavioral health care in the following areas: adherence to antipsychotic medications for members with schizophrenia, depression screenings, and follow-up care for children prescribed ADHD medication.	✓	✓	✓
Performance Measures	It is recommended that GEI work to improve dental and oral health services, particularly topical fluoride for children ages 1−2 years.	✓	✓	✓
Performance Measures	It is recommended that GEI work to improve care surrounding diabetes, focusing on members that received statin therapy as part of their diabetes treatment.	✓	-	✓
Performance Measures	It is recommended that GEI work to improve maternal and perinatal health care in the following areas: (1) focusing on accessibility of LARC within 90 days of delivery for postpartum women, (2) prenatal screening for environmental tobacco smoke (ETS) exposure, and (3) prenatal smoking cessation.	✓	✓	✓
Performance Measures	It is recommended that GEI work to improve in areas of overuse or appropriateness by focusing on avoidance of antibiotic treatment for members diagnosed with acute bronchitis or bronchiolitis.	✓	✓	-
Performance Measures	It is recommended that GEI focuses improvement on prevention and screening in the following areas: (1) development screenings in the first three years of a member's life, (2) chlamydia screenings for member age 16−24 years, and (3) adolescent immunizations for HPV and Combination 2.	✓	✓	✓
Performance Measures	It is recommended that GEI work to improve care for respiratory conditions for both appropriate testing for pharyngitis and asthma medications.	✓	-	-
Performance Measures	It is recommended that GEI work to improve ambulatory care emergency department and outpatient utilization, as well as working to reduce admissions due to short-term complications related to diabetes.	✓	✓	✓
Compliance with Medicaid and CHIP Managed Care Regulations	No recommendations	✓	✓	✓
Quality-of-Care Surveys	GEI should focus on improving adult member satisfaction in getting needed information and satisfaction with health care. For members ages 17 years and younger, GEI should focus on satisfaction with the child's health plan, information or help from customer service, and satisfaction with health care.	✓	-	✓

EQR: external quality review; PIP: performance improvement project; CHIP: Children's Health Insurance Program; MCO: managed care organization; ED: emergency department; MY: measurement year; MMC: Medicaid managed care; ADHD: attention deficit hyperactivity disorder; LARC: long-acting reversible contraception.

P4P Measure Matrix Report Card 2023 (MY 2022)

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

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

A matrix represents the comparisons in each of **Figures 1−2.** In **Figure 1**, the horizontal comparison represents the MCO's current performance as compared to the most recent MMC weighted average. When comparing an MCO's rate to the MMC weighted average for each respective measure, the MCO rate can be either above average, average, or below average. For each rate, the MCO's performance is determined using a 95% CI for that rate. The difference between the MCO rate and MMC weighted average is statistically significant if the MMC weighted average is not included in the range, given by the 95% CI. When noted, the MCO comparative differences represent statistically significant differences from the MMC weighted average.

The vertical comparison represents the MCO's performance for each measure in relation to its prior year's rates for the same measure. The MCO's rate can trend up (⇧), have no change, or trend down (⇩). For these year-to-year comparisons, the statistical significance of the difference between two independent proportions was determined by calculating the *Z* ratio. Noted comparative differences denote statistically significant differences between the years.

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

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

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

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

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

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

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

GEI Key Points

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

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

- Annual Dental Visit (Ages 2−20 years)

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

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

- Lead Screening in Children

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

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

- Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) [19]
- Controlling High Blood Pressure
- Prenatal Care in the First Trimester
- Postpartum Care

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

- Child and Adolescent Well-Care Visits (Ages 3−21 years)
- Plan All-Cause Readmissions[20]

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

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

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

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

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

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

- Developmental Screening in the First Three Years of Life

		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** Annual Dental Visit (Ages 2–20 years)
	No Change	**D** Asthma Medication Ratio Well–Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits)	**C** Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) Controlling High Blood Pressure Prenatal Care in the First Trimester Postpartum Care	**B** Lead Screening in Children
	↓	**F** Developmental Screening in the First Three Years of Life	**D**	**C** Child and Adolescent Well-Care Visits (Ages 3–21 years)

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

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

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

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

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

Table 40: P4P Measure Rates

Quality Performance Measure – HEDIS Percentage Rate Metric[1]	HEDIS MY 2019 Rate		HEDIS MY 2020 Rate		HEDIS MY 2021 Rate		HEDIS MY 2022 Rate		HEDIS MY 2022 MMC WA
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c >9.0% (poor control) [2]	29.1%	=	33.6%	=	29.0%	=	29.2%	=	32.3%
Controlling High Blood Pressure	71.8%	=	71.5%	=	67.6%	=	71.1%	=	70.3%
Prenatal Care in the First Trimester	91.7%	▲	88.3%	=	86.4%	=	88.8%	=	88.7%
Postpartum Care	82.0%	▲	77.4%	=	80.1%	=	79.6%	=	81.6%
Annual Dental Visits (Ages 2–20 years)	54.4%	▼	45.7%	▼	55.2%	▲	65.4%	▲	63.2%
Well–Child Visits in the First 30 Months: First 15 Months of Life (Six or more visits)	74.1%	=	66.4%	▼	65.2%	=	66.0%	=	68.1%
Child and Adolescent Well-Care Visits (Ages 3–21 years)	N/A		N/A		55.6%	▼	57.0%	▲	58.9%
Asthma Medication Ratio	N/A		65.5%	=	64.2%	=	62.9%	=	66.3%
Lead Screening in Children	82.2%	=	88.3%	▲	84.4%	=	86.6%	=	81.9%

Quality Performance Measure – HEDIS Percentage Rate Metric[1]	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2022 MMC WA
Quality Performance Measure – Other Percentage Rate Metric	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2022 MMC WA
Developmental Screening in the First Three Years of Life (CMS Child Core)	65.4% ▲	63.9% ▼	50.2% ▼	32.0% ▼	62.0%
Quality Performance Measure – HEDIS Ratio Metric	HEDIS MY 2019 Ratio	HEDIS MY 2020 Ratio	HEDIS MY 2021 Ratio	HEDIS MY 2022 Rate	HEDIS MY 2022 MCO Average
Plan All-Cause Readmissions[3]	N/A	0.78 ▼	0.68 =	0.78 =	0.96

[1] Statistically significant difference is indicated for all measures except Plan All–Cause Readmissions. For this measure, differences are indicated based on absolute differences in the observed-to-expected ratio between years.

[2] Lower rates for Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c was >9.0% (poor control) indicate better performance.

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

P4P: Pay-for-Performance; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; MMC: Medicaid Managed Care; WA: weighted average; CMS: Centers for Medicare and Medicaid Services; MCO: managed care organization; N/A: not applicable, the measure was not included in the P4P program that measurement year.

IX. Appendix A

Performance Improvement Project Interventions

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

Table A1: PIP Interventions

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

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

X. Appendix B

Race and Ethnicity

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

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

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

- The following rates are statistically significantly above/better than the MY 2022 MMC weighted average:
  - Colorectal Cancer Screening - Ethnicity: Hispanic or Latino - 4.9 percentage points
  - Colorectal Cancer Screening - Ethnicity: Not Hispanic or Latino - 3.7 percentage points
  - Colorectal Cancer Screening - Race: Black or African American - 5.3 percentage points

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

- The following rates are statistically significantly below/worse than the MY 2022 MMC weighted average:
  - Child and Adolescent Well-Care Visits - Race: Asked but No Answer - 7.6 percentage points
  - Colorectal Cancer Screening - Ethnicity: Unknown - 8.0 percentage points
  - Colorectal Cancer Screening - Race: Unknown - 6.0 percentage points
  - Controlling High Blood Pressure - Race: White - 5.1 percentage points

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

Table B1: Race and Ethnicity Measure Data

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Child and Adolescent Well-Care Visits	Ethnicity: Asked but No Answer	165	101	61.2%	53.5%	68.9%	61.2%	n.s.
Child and Adolescent Well-Care Visits	Ethnicity: Hispanic or Latino	15,203	9,171	60.3%	59.5%	61.1%	61.2%	–
Child and Adolescent Well-Care Visits	Ethnicity: Not Hispanic or Latino	77,577	43,860	56.5%	56.2%	56.9%	58.3%	–
Child and Adolescent Well-Care Visits	Ethnicity: Unknown	4,144	2,196	53.0%	51.5%	54.5%	55.8%	–
Child and Adolescent Well-Care Visits	Race: American Indian and Alaska Native	216	115	53.2%	46.4%	60.1%	57.7%	n.s.
Child and Adolescent Well-Care Visits	Race: Asian	1,140	696	61.1%	58.2%	63.9%	62.8%	n.s.
Child and Adolescent Well-Care Visits	Race: Asked but No Answer	479	272	56.8%	52.2%	61.3%	64.4%	–
Child and Adolescent Well-Care Visits	Race: Black or African American	10,746	6,088	56.7%	55.7%	57.6%	56.2%	n.s.
Child and Adolescent Well-Care Visits	Race: Native Hawaiian and Other Pacific Islander	1,297	754	58.1%	55.4%	60.9%	57.2%	n.s.
Child and Adolescent Well-Care Visits	Race: Some Other Race	154	100	64.9%	57.1%	72.8%	61.8%	n.s.
Child and Adolescent Well-Care Visits	Race: Two or More Races	14	10	N/A	N/A	N/A	62.1%	N/A
Child and Adolescent Well-Care Visits	Race: Unknown	3,213	1,827	56.9%	55.1%	58.6%	59.4%	–
Child and Adolescent Well-Care Visits	Race: White	79,830	45,466	57.0%	56.6%	57.3%	59.2%	–
Colorectal Cancer Screening	Ethnicity: Asked but No Answer	90	46	51.1%	40.2%	62.0%	51.1%	n.s.
Colorectal Cancer Screening	Ethnicity: Hispanic or Latino	2,448	1,167	47.7%	45.7%	49.7%	42.8%	n.s.
Colorectal Cancer Screening	Ethnicity: Not Hispanic or Latino	25,491	10,772	42.3%	41.7%	42.9%	38.5%	+
Colorectal Cancer Screening	Ethnicity: Unknown	1,313	365	27.8%	25.3%	30.3%	35.8%	+
Colorectal Cancer Screening	Race: American Indian and Alaska Native	91	39	42.9%	32.1%	53.6%	38.4%	+
Colorectal Cancer Screening	Race: Asian	384	172	44.8%	39.7%	49.9%	41.0%	+

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Colorectal Cancer Screening	Race: Asked but No Answer	194	94	48.5%	41.2%	55.7%	42.2%	–
Colorectal Cancer Screening	Race: Black or African American	1,745	689	39.5%	37.2%	41.8%	34.2%	–
Colorectal Cancer Screening	Race: Native Hawaiian and Other Pacific Islander	237	116	49.0%	42.4%	55.5%	49.0%	n.s.
Colorectal Cancer Screening	Race: Some Other Race	40	17	42.5%	25.9%	59.1%	38.9%	n.s.
Colorectal Cancer Screening	Race: Two or More Races	7	4	N/A	N/A	N/A	40.4%	n.s.
Colorectal Cancer Screening	Race: Unknown	565	180	31.9%	27.9%	35.8%	37.9%	n.s.
Colorectal Cancer Screening	Race: White	26,079	11,039	42.3%	41.7%	42.9%	40.4%	n.s.
Controlling High Blood Pressure	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	0.0%	n.s.
Controlling High Blood Pressure	Ethnicity: Hispanic or Latino	44	32	72.7%	58.4%	87.0%	68.0%	+
Controlling High Blood Pressure	Ethnicity: Not Hispanic or Latino	358	255	71.2%	66.4%	76.1%	70.6%	+
Controlling High Blood Pressure	Ethnicity: Unknown	9	5	N/A	N/A	N/A	70.4%	n.s.
Controlling High Blood Pressure	Race: American Indian and Alaska Native	1	1	N/A	N/A	N/A	50.8%	n.s.
Controlling High Blood Pressure	Race: Asian	3	3	N/A	N/A	N/A	74.3%	n.s.
Controlling High Blood Pressure	Race: Asked but No Answer	4	4	N/A	N/A	N/A	58.9%	n.s.
Controlling High Blood Pressure	Race: Black or African American	31	21	67.7%	49.7%	85.8%	58.3%	N/A
Controlling High Blood Pressure	Race: Native Hawaiian and Other Pacific Islander	5	3	N/A	N/A	N/A	60.0%	N/A
Controlling High Blood Pressure	Race: Some Other Race	2	1	N/A	N/A	N/A	58.0%	–
Controlling High Blood Pressure	Race: Two or More Races	1	1	N/A	N/A	N/A	74.3%	–
Controlling High Blood Pressure	Race: Unknown	5	2	N/A	N/A	N/A	63.1%	+
Controlling High Blood Pressure	Race: White	359	256	71.3%	66.5%	76.1%	76.4%	+
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Asked but No Answer	2	0	N/A	N/A	N/A	0.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Hispanic or Latino	53	28	52.8%	38.4%	67.2%	52.7%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Not Hispanic or Latino	340	213	62.7%	57.4%	67.9%	59.1%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Ethnicity: Unknown	16	8	N/A	N/A	N/A	55.3%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: American Indian and Alaska Native	2	2	N/A	N/A	N/A	48.2%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Asian	6	4	N/A	N/A	N/A	65.9%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Asked but No Answer	5	2	N/A	N/A	N/A	62.9%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Black or African American	36	21	58.3%	40.8%	75.8%	53.1%	n.s.
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Native Hawaiian and Other Pacific Islander	4	3	N/A	N/A	N/A	75.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Some Other Race	1	1	N/A	N/A	N/A	56.6%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Two or More Races	0	0	N/A	N/A	N/A	65.5%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: Unknown	8	5	N/A	N/A	N/A	54.9%	N/A
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	Race: White	349	211	60.5%	55.2%	65.7%	58.7%	–

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Asked but No Answer	2	1	N/A	N/A	N/A	50.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Hispanic or Latino	53	21	39.6%	25.5%	53.7%	35.7%	n.s.
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Not Hispanic or Latino	340	91	26.8%	21.9%	31.6%	31.6%	n.s.
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Ethnicity: Unknown	16	7	N/A	N/A	N/A	34.6%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: American Indian and Alaska Native	2	0	N/A	N/A	N/A	16.2%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Asian	6	1	N/A	N/A	N/A	19.8%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Asked but No Answer	5	3	N/A	N/A	N/A	29.4%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Black or African American	36	13	36.1%	19.0%	53.2%	37.7%	n.s.
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Native Hawaiian and Other Pacific Islander	4	1	N/A	N/A	N/A	25.0%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Some Other Race	1	0	N/A	N/A	N/A	34.1%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Two or More Races	0	0	N/A	N/A	N/A	26.2%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: Unknown	8	2	N/A	N/A	N/A	31.5%	N/A
Hemoglobin A1c Control for Patients With Diabetes – Poor HbA1c Control	Race: White	349	100	28.7%	23.8%	33.5%	31.7%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	0.0%	N/A
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Hispanic or Latino	66	57	86.4%	77.3%	95.4%	83.8%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Not Hispanic or Latino	335	263	78.5%	74.0%	83.1%	81.1%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Ethnicity: Unknown	10	7	N/A	N/A	N/A	75.8%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: American Indian and Alaska Native	2	1	N/A	N/A	N/A	52.7%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Asian	5	4	N/A	N/A	N/A	89.5%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Asked but No Answer	5	4	N/A	N/A	N/A	91.6%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Black or African American	49	37	75.5%	62.4%	88.6%	77.2%	n.s.
Prenatal and Postpartum Care - Postpartum Care	Race: Native Hawaiian and Other Pacific Islander	4	3	N/A	N/A	N/A	75.0%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Some Other Race	0	0	N/A	N/A	N/A	86.5%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Two or More Races	0	0	N/A	N/A	N/A	84.1%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: Unknown	11	9	N/A	N/A	N/A	86.1%	N/A
Prenatal and Postpartum Care - Postpartum Care	Race: White	335	269	80.3%	75.9%	84.7%	82.3%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Asked but No Answer	0	0	N/A	N/A	N/A	0.0%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Hispanic or Latino	66	59	89.4%	81.2%	97.6%	89.8%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Not Hispanic or Latino	335	298	89.0%	85.5%	92.5%	88.5%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Ethnicity: Unknown	10	8	N/A	N/A	N/A	80.0%	N/A

Measure Name	Race/Ethnicity	MY 2022 Denom	MY 2022 Num	MY 2022 Rate	MY 2022 Lower 95% Confidence Limit	MY 2022 Upper 95% Confidence Limit	MY 2022 MMC	MY 2022 Rate Compared to MMC[1]
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: American Indian and Alaska Native	2	1	N/A	N/A	N/A	50.8%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Asian	5	5	N/A	N/A	N/A	91.7%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Asked but No Answer	5	5	N/A	N/A	N/A	92.8%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Black or African American	49	44	89.8%	80.3%	99.3%	85.6%	n.s.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Native Hawaiian and Other Pacific Islander	4	3	N/A	N/A	N/A	75.0%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Some Other Race	0	0	N/A	N/A	N/A	90.2%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Two or More Races	0	0	N/A	N/A	N/A	87.7%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: Unknown	11	10	N/A	N/A	N/A	91.5%	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	Race: White	335	297	88.7%	85.1%	92.2%	90.2%	n.s.

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